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# A Realistic Evaluation of a Tool to Assess the Interpersonal Skills of Pre-Registration Nursing Students

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Thesis submission for admission to
degree of Doctor of Philosophy
in Professional Education

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## Abstract

The Interpersonal Skills Profile (ISP) is a tool that explicitly evaluates motivation, attitude, maturity and other attributes in the clinical practice setting. It has been adapted by a variety of healthcare programmes in Higher Education Institutions (HEIs) in the UK. Despite widespread use, there is no previous research on how the ISP is used in practice. Using one HEI's version of the ISP, this study set out to ask: **How is a tool designed to assess the interpersonal skills of pre-registration nursing students used in practice?**

Using a Realistic Evaluation approach, interview and documentary data were analysed to identify contexts, mechanisms and outcomes mapping the ISP's use in practice. Face to face or telephone interviews were conducted with clinical nurse mentors, Practice Education Facilitators and Education Champions (nursing faculty linking to clinical areas). The documentary data came from students' practice assessment documents.

Analysis identified four context-mechanism-outcome (CMO) configurations named after their main contexts. CMO1: '*Interpersonal skills are hard to assess'* includes four mechanisms; that what and when to assess is explicit, mentors have permission to assess, there is a place to document assessments, and the consequences of the assessment are clear to mentors and students. CMO2: '*Mitigating mentor weaknesses'* comprises three mechanisms that support struggling mentors; the ISP provides distance, prompts assessment and legitimises assessment of interpersonal skills. CMO3: '*Clinical setting variability'* contains two mechanisms that mitigate variation: 'levelling' and 'enabling' assessment. CMO4: '*Variability of mentors' experiences and students' expectations'* has four mechanisms; the ISP provides clarity through requiring evidence, supports feedback and raises awareness of the consequences of assessment for all students and assessors. Realistic Evaluation focuses on mechanisms abstracted from the specific context. The mechanisms described in this study may have resonance and analytic power in other contexts.

In addition, four conceptual models were abstracted in this study. Firstly, a 'spiral of raised awareness' captures complexity following implementation of an intervention and contributes to knowledge around using Realistic Evaluation. Subsequently, three middle-range theories (MRTs) predict what works to support assessment of interpersonal skills: clear requirements (MRT1), a simple tool (MRT2) and overt feedback with clear consequences (MRT3). These MRTs contribute to knowledge of interpersonal skills assessment theory and the development of assessment tools.

## Abbreviations

| | |
|---|---|
| A*f*L | Assessment *for* Learning |
| AACS | Amsterdam Attitude and Communication Scale |
| ACAT | acute care assessment tool |
| APP | Assessment of Physiotherapy Practice |
| CBD | case-based discussion |
| CMO | context-mechanism-outcome |
| CORD | Council of Emergency Medicine Residency Directors |
| DoH | Department of Health |
| EC | education champion |
| ESC | essential skills cluster |
| ENB | English National Board for Nursing, Midwifery and Health Visiting |
| HEI | higher education institution |
| ISP | interpersonal skills profile |
| KI | key informant |
| mini-CEX | mini-clinical evaluation exercise |
| MRT | middle range theory |
| NCAS | National Clinical Assessment Service |
| NHS | National Health Service |
| NMC | Nursing and Midwifery Council |
| NOTSS | Non-Technical Skills for Surgeons |
| OSCE | objective structured clinical examination |
| OT | occupational therapy |
| PEF | practice education facilitator |
| P-MEX | Professional Mini-Examination |
| RCN | Royal College of Nursing |
| SLAiP | Standards to support learning and assessment in practice |
| SPEF-R | Student Placement Evaluation Tool- Revised |
| SDOT | Standardized Direct Observational Assessment Tool |
| UK | United Kingdom |
| US | United States |

# 1. Introduction

## 1.1. Structure of the thesis

The thesis has been organised into eight sections. Chapter one sets the scene of the study, explaining some of the history of the Higher Education Institution (HEI) where the study took place and the practice assessment strategy and tools that were examined. It starts with nursing education in the United Kingdom (UK) and touches on mentorship and standards to support learning in practice. The particular setting is then described and the practice assessment strategy of the study HEI discussed. Appendix A presents the Interpersonal Skills Profile (ISP) in its entirety [staring on p. 255]. Relevant details of the HEI's former and current (at the time of the study) practice assessment documents can be found in Appendix B.

In chapter two the literature on professional education is reviewed, emphasising the issues of licensing, complexity and working with people. Overall, the review focuses on healthcare professions and nursing education. Within nursing, challenges relating to practice documents, mentorship and mentor preparation are explored; complex issues around assessing interpersonal skills and professionalism are summarised, including implicit assessment and self-assessment. Some assessment tools that incorporate an interpersonal skills element are reviewed. The particular tool examined in this study, the ISP, is presented with some of the context surrounding its development and use. From gaps identified in the literature, the primary research question emerges along with secondary questions and the aims of the study [see p. 59].

Chapter three sets out the methodological approach chosen for the study. Realistic Evaluation is introduced alongside a brief history of evaluation research and the underlying philosophy of critical realism. Strengths and weaknesses of Realistic Evaluation are then discussed alongside a review of studies that used the approach, particularly in healthcare and education. The study design is outlined, and the groups of research participants described. Ethical issues relating to the different groups of research participants are discussed. Issues around mixing two qualitative research methods are covered. The data collection methods are

described including the influence of Appreciative Inquiry on interviewing. The complementary documentary analysis is also discussed. The approach to data analysis is outlined, including a discussion of qualitative analysis using Interpretive Description. Finally, some reflections on insider research close the Methodology chapter.

Chapter four describes the retroductive—back and forth between induction and deduction—data analysis process for interview and documentary materials. Initial context-mechanism-outcome configurations (CMOs) are presented with an 'audit trail' of how the data categories and configurations were developed.

Chapters five and six present the findings of the analysis at different levels of abstraction. In chapter five, CMOs are grounded in the research context with an exploration of the mechanisms at work. Each CMO is also challenged by returning to the interview data and practice documents. Chapter six takes the analysis one step further to develop four new conceptual models. Firstly, the 'spiral of raised awareness' explores the way in which context continually changes and shapes mechanisms and outcomes which then alter contexts. Secondly, three middle range theories are proposed: these predict what works to support assessment of interpersonal skills.

In the Discussion, chapter seven, the research questions are revisited and ideas raised in the Findings chapters are examined further. A critique of Realistic Evaluation follows. Assessment *for* learning, the gate-keeping role of mentors and the influences of subjectivity and bias in interpersonal skills assessment are discussed.

Chapter eight concludes the thesis. Limitations of the study are explored, and its contributions to knowledge are described. Some recommendations for practice and further research are proposed. Finally, a brief reflection on the process of studying and a reiteration of the key points of the study are made.

This thesis will demonstrate that I have critically engaged with the literature on practice assessment, particularly around interpersonal skills. Through this

engagement I have identified a question that contributes to the development of knowledge in this field and addressed it through an empirical study, using Realistic Evaluation. Every research approach has strengths and weaknesses. The strengths and weaknesses of Realistic Evaluation are explored in the Methodology chapter. The Data Analysis chapter aims to demonstrate the fidelity of this study's analysis to the Realistic Evaluation approach. The Findings and Discussion provide insights into the field of practice assessment, particularly that of assessing interpersonal skills. The Conclusion summarises the study and highlights its contributions to knowledge.

## 1.2. Nursing education in the United Kingdom

### *1.2.1. Practice education in pre-registration nursing*

In the UK, pre-registration nursing education is split into 50% theory and 50% practice[1] experience. Successful completion of theory and clinical components confers both an academic qualification[2] and a professional qualification, in the absence of a national registration exam. In the past, UK nursing students were employees of the National Health Service (NHS) and small nursing schools were closely aligned with teaching hospitals where clinical teachers assessed students on structured clinical tasks (Gerrish, 2000). Some argue that the loss of this apprenticeship model has led to inadequate practical nurse preparation (Bradshaw & Merriman, 2008). Currently, students are supernumary in practice areas, that is, they are not part of the NHS workforce and are not 'counted in the numbers' of staff on a particular shift. Students are assigned to a wide range of placements by large HEIs that may be affiliated with several hospitals and other clinical areas. In practical placements, practice is supervised and assessed by clinical nursing staff known as mentors. Mentors have received increasing levels of preparation over recent years (Nursing and Midwifery Council (NMC) & Mitchell 2008; NMC 2008a) but they are given no extra time or financial compensation for supervising and assessing students (Burke & Saldanha, 2005).

[1] In nursing education periods of supervised professional practice are referred to as 'practice' and university-based studies as 'theory', these terms will be used throughout the thesis.
[2] Since 2011 academic qualification is at degree level, previously education was offered at either diploma or degree level.

In the UK nursing and nurse education are divided into fields[3]—Adult, Child, Mental Health and Learning Disability—and students specialise after an initial 'common foundation' year. Placement areas are usually allocated according to the population (adults, children etc.) that the student will be working with once qualified. Smaller fields (like Child and Learning Disability fields) sometimes operate with 'base placements' where the student is placed over the three year programme with brief experiences elsewhere. In larger fields (such as Adult and Mental Health) students usually change placements at least every six months and rarely return to the same placement.

#### 1.2.1.1. Increasing student numbers

In the past decade, student numbers have increased as the workforce and the population ages (Royal College of Nursing (RCN), 2011). Nursing meanwhile, continues to experience a high attrition rate both in training and in the workforce (Maben et al., 2006; Mallik & Hunt, 2007; Urwin et al., 2010). During the data collection period student numbers peaked, before declining with the introduction of the degree entry to education in September 2011 (RCN, 2011). Despite this decline, the number of student nurses in 2011 was still higher than in the 1990s (RCN, 2002). The increase in student numbers puts pressure on HEIs, resulting in larger classes. It strains the level of individual support that can be provided. The problem is further amplified in practice as placement capacity is relatively fixed. Ensuring that students are exposed to sufficient and varied placements is thus an on-going challenge (Kenyon & Peckover, 2008; Zhang et al., 2008).

#### 1.2.1.2. Mentorship in the United Kingdom

In the UK, the mentorship model has been widely adopted as a means to support the 50% practice component of pre-registration nursing education. Although terminology around clinical support roles has not been standardised (Bray & Nettleton, 2007; Yonge et al., 2007; Hyatt et al., 2008), in this thesis the term mentor refers to a clinical nurse—with no employment relationship with the HEI

[3] In 2011, field replaced the term branch of nursing in the UK. The updated term field will be used throughout the thesis, however, quotes from participants use branch, which was current at the time of interview.

and a normal clinical workload—who takes on student teaching and assessment. This reflects the English National Board (ENB) and Department of Health (DoH) definition "…*the nurse, midwife or health visitor who facilitates learning and supervises and assesses students in the practice setting*" (ENB & DoH 2001 p. 6). Mentorship is added to nurses' usual duties and so they have to face the challenges of combining their clinical practice roles with the roles of teaching, supporting, supervising and assessing pre-registration nursing students (Gilmore, 1999) [see section 2.3.1.2].

#### 1.2.1.3. Nursing and Midwifery Council: Standards to support learning and assessment in practice (SLAiP)

Preparation of mentors in the UK has been variable, ranging from in-house and on-the-job training to nationally recognised courses delivered by HEIs. To address this disparity, the Nursing and Midwifery Council (NMC), the UK's registration and standards body for nurses and midwives, instituted minimum requirements for mentor preparation and education in 2006 (NMC, 2006). The NMC guidance formalises regulations for the preparation of mentors (NMC, 2008b) including educational requirements and specific content concerning student feedback and support. After a national consultation, the NMC also defined essential skills clusters (ESCs) to be integrated into practical placement learning and assessment (NMC, 2007a; Thewlis, 2007). The five pre-registration nursing ESCs are: 1) care, compassion and communication; 2) organisational aspects of care; 3) infection prevention and control; 4) nutrition and fluid management and 5) medicines management. The ESCs have been mapped to the standards for pre-registration nursing education set by the NMC in 2004 (NMC, 2007c) and have been implemented nationally since September 2008. This guidance provides some consistency in expectations of levels of achievement in different years of the pre-registration programme and across clinical areas.

Despite this guidance at the national level, each HEI continues to develop its own academic and practical placement assessment documentation. This study focused on the Interpersonal Skills Profile (ISP) [see section 2.4], a specific assessment instrument employed within a larger assessment document [see Appendix A for an example of the ISP on p. 255 and Appendix B for details of the HEI's practice

assessment document as a whole]. The ISP assesses some aspects of the care, compassion and communication ESC, which have been notoriously difficult to capture [see section 2.3.2.2].

## 1.3. The research setting

This study was carried out in a post-1992 university Faculty of Health and Social Care, which was formed from two separate schools of nursing, at three sites (A, B and C) [see sections 1.3.1.1 and 1.3.1.2]. The merger, locally referred to as convergence, began in 2005 and was concluded in 2007. Data collection began in January 2009 to allow a period of adjustment and experience of the new curriculum and resulting documents [see Methodology, section 3.5]. Prior to convergence I had been employed at site B and also taught at site A, which together formed one school of nursing. I continued working for the new faculty for a year post-convergence before moving into the clinical area as a practice development nurse in one hospital department [see Figure 10, p. 94 for a visual timeline].

### *1.3.1. Two institutions merge*

Prior to convergence, one institution had been an independent school of nursing and midwifery located at two academic sites (A and B). It merged with an institute of health sciences that had been embedded in a post-1992 university (site C). The newly created faculty of health and social care, organisationally located within the post-1992 university (the study HEI), retained three academic sites and continued to make use of a very large number of clinical areas, spanning several counties, for student placements. This geographic spread posed a considerable challenge for HEI support of practice areas, particularly in community and independent sector placements.

In order to provide some background information, the two institutions' previous ways of organising student learning (parts vs. modules) and assessing students in practice are outlined below [see sections 1.3.1.1 and 1.3.1.2]. Prior to convergence both institutions had attempted to address interpersonal skills and professionalism but it was implicit in the practice documents [see Literature Review section 2.3.2.2] and did not form a summative part of the assessment.

#### 1.3.1.1. Sites A and B: pre-convergence practice assessment

At sites A and B the three-year programme was divided into five parts with particular learning outcomes (academic and practice) to be achieved in each part. The parts had different practice criteria, reflected in a variety of practice assessment booklets. Documentation for each part varied, encompassing four to seven separate booklets that addressed topics ranging from communication to wound assessment, and included lists of criteria to be signed off by mentors. Each skill-based booklet had free-text space for students to answer evidence-based questions about the particular skill, to record their own reflections and for the mentor to comment. Each part of the programme also had a generic booklet with a 'verification of development of professional practice' section that addressed issues such as working in a team and following the NMC Code of Conduct (NMC, 2008) [for examples see Appendix B].

#### 1.3.1.2. Site C: pre-convergence practice assessment

The three-year programme on site C was modular with four modules to be completed per year. Two modules (together known as a session) were assessed using a single practice booklet. The booklets contained checklists of criteria for achievement of skills to be signed off. For each module there was free-text space for students to comment on their own progress. The mentor was asked to comment on areas of student performance both for commendation and for development. NMC standards for proficiency required to enter the field or the register (as appropriate) were included in each document as a table, although these were not specifically assessed [for examples see Appendix B].

Some mentors at a hospital associated with site C also had students from another HEI and were therefore exposed to a second set of practice documents. These two programmes continued to run in shared clinical areas throughout the data collection period.

#### 1.3.1.3. Assessment Regulations

The convergence brought with it a curriculum approved by the NMC for five years (from 2007 to 2012), a new practice assessment strategy and practice assessment

document. The ISP fitted within this system as one tool within the larger practice assessment document. Regulations for student assessment in the new faculty allowed a minimum of two attempts to pass any placement or theory assignment. Another possibility to avoid withdrawing from the programme due to failure was to offer students a chance to 'interrupt' or 'intermit' their studies. Students could then re-join the cohort six months to a year behind their original cohort and start the module afresh. Mentors may or may not have been aware that failing a student in practice did not (either pre or post convergence) mean ending their career in nursing [see section 2.3.1.2].

The converged faculty adopted the modular and sessional structure of site C [see 1.3.1.2]. Student nurses progressed through 12 modules (divided into six sessions) over three years. Clinical placements were allocated per session, thus students completed two modules in the same clinical setting. Post-convergence assessment of practice is outlined more fully in Appendix B. The modules proceeded on a tight schedule and due to the timing of exam boards (which could be held a month or two after the end of a module), students could begin and might have nearly completed the next module before ratification of their success or failure in the previous module. Failures, both in theory and in practice were 'carried over' to be redone in the next module. The impact in practice was that the student was assessed on two practice documents in the following module, possibly in a completely different practice setting than that in which the original fail was accrued.

## 1.4. Conclusion of the introduction

The study took place in a newly formed three-site faculty of Health and Social Care after the convergence of a school of nursing and a healthcare institute. At the time of data collection students followed diploma or degree level theory components but were assessed identically in their practical placements. Students on any of the three sites could be following their programme in any of the fields of nursing, i.e. Adult, Child, Mental Health or Learning Disability, with small numbers enrolled on the Child and Learning Disability fields. New assessment documents and regulations had been introduced a year prior to the beginning of data collection.

# 2. Literature review

The empirical focus of this study was on healthcare professions and nursing in particular, however, there are common issues across professions. Professions as diverse as architecture and social work have a 'craft' knowledge (Eraut, 1994) that must be passed on to those starting out in the profession. Additionally, all professions interact with the public—as clients, patients, users, etc.—and work together in (sometimes inter-professional) teams, thus requiring well-developed interpersonal skills. This Literature Review therefore draws on examples from a wide range of professions. It explores professional education, focusing on particular challenges such as licensure, complexity and working with people. These areas are further explored within healthcare professions, especially within nursing. The nature of interpersonal skills and the challenges of teaching and assessing them explicitly are discussed. Some tools that incorporate an interpersonal skills assessment element are examined. The chapter closes with a presentation of the research questions for this study.

## 2.1. The Literature Review Process

The literature review was traditional, i.e. a critical narrative examination of previously published work rather than a systematic review (Jesson et al., 2011). The review covered literature on professional education, interpersonal skills, and assessment theory and practice. A variety of databases were searched, specifically healthcare and healthcare education databases such as CINAHL (the Cumulative Index to Nursing and Allied Health Literature) and MEDLINE (database of the US National Library of Medicine). The main educational resource was ERIC (the Education Resources Information Center database). Broader databases included JSTOR (a journal storage archive), SWETSWISE (information management) and publishing company databases such as Elsevier's ScienceDirect and SCOPUS. Google Scholar was used particularly to search for articles that had been cited by key references used in the literature review. Keywords were added and searched in a variety of databases as the literature review expanded and over the course of the study. They included both content keywords (e.g. interpersonal skills, assessment, assessment tools, interpersonal skills assessment tools, clinical

practice, nursing, nursing students, professional education and authentic assessment) and methodology keywords (e.g. Realistic Evaluation, interviewing and qualitative data analysis). As with many literature reviews the search was initially broad, becoming more focused over the course of the review and study (Polit & Hungler, 1995). As education and assessment literature and theories have evolved over time, recent articles were given preference and the literature review was continually updated over the course of the research and writing up period. Updating was aided by tools such as automatic alerts and table of content alerts for key journals. Some of the initial searches were re-run in databases in later years. Key works that were frequently cited by current authors were reviewed. For example Bondy's (1983) influence on clinical assessment tools in the United States (US) or classic literature in evaluation research (Stake, 1973; Chen & Rossi, 1983) were reviewed. Only articles published in English were read but authors came from many countries including Turkey (Celik et al., 2012), Israel (Orland-Barak & Wilhelem, 2005; Orland-Barak & Yinon, 2005), China (Zhang et al., 2001; Tang, 2008), and South Africa (Shay, 2008). The majority of studies came from European countries such as the Netherlands, Finland, Sweden, France and the UK, as well as the US, Canada, New Zealand and Australia. Each article was recorded using the Bookends Referencing Software (Sonny Software 2009) and evaluated noting the research approach, participant group, findings and so on. No particular framework was used but evaluation of the literature was influenced by Polit and Hungler's critical frameworks as outlined in their 1995 book.

## 2.2. Professional education

Professions are characterised as occupations that have both formal knowledge and less tangible craft knowledge, which require intense periods of training and have a form of regulation (Eraut, 1994). It is beyond the scope of this thesis to precisely catalogue the occupational groups that constitute professions or the specific characteristics that define them. However, a focus of this study was an exploration of how professional education teaches and assesses professional *behaviour* (Roberts & Johnson, 2009). An integral part of almost all professional practice is interacting with people; therefore, interpersonal skills and attitudes make up an important part of professional learning.

Interpersonal skills, behaviours and attitudes are difficult to define and often seem inherently subjective, however, studies have been undertaken to characterise them. In a review of the medical professionalism literature, Hilton and Slotnick (2005) identified six features of professionalism in medical students: ethical practice; reflection/self-awareness; responsibility for actions; respect for patients; teamwork and social responsibility. By substituting client/customer/user for patient, these features may be applied to almost any field. In another extensive literature review, van de Camp and colleagues (2004) conceived of professionalism as having three interlinking strands: interpersonal, public and intrapersonal. Here too, the precise content varies with the discipline, however this seems a useful way to acknowledge that professionalism is a complex construct, referring to the professional-client relationship as well as expectations of how members of professional groups should behave.

Professional education is a joint venture, partnering the educating institution (now usually a university or HEI, formerly professional schools) and the professional practice (workplace) setting (Edwards & Mutton, 2007; Mallik & McGowan, 2007). This is implemented in a variety of ways including short periods of observation, apprenticeships, integrated periods of supervised professional practice and university-based studies, or a period of practice experience after completion of an academic degree (Chappell & Hawke, 2005). In each case, graduates are expected to have learnt profession-specific knowledge as well as the practice of their profession in order to be registered or recognised as professional practitioners (Smeby, 2007). In contrast with more theoretical fields such as the humanities and sciences, elements of practical professional education are often beyond the control of the authorising body, in this case the HEI, compelling the authorising body to rely on the willingness and ability of practitioners to transmit their specialist skills (Baartman et al., 2007). Newton and colleagues (2009) highlight the fact that not all students can be supported in the same setting, resulting in disparities in focus and ability to support students in the environments in which students must learn the practical element of their profession. Furthermore, HEIs and practice settings may not share common priorities, the taught theoretical knowledge may differ from the reality of its implementation in practice, and students may face divergent curricula. This tension can lead to what, in many disciplines, is called the theory-

practice gap (Richter & Allert, 2004; Maben et al., 2006; Heggen, 2008; Gallagher, 2010).

Although placements in practical settings are a vital part of professional education, learning does not automatically happen as a result of being in proximity with a professional (Eraut, 2007). Learning how to behave as a member of the profession is part of professional education (Fitzpatrick et al., 1996), and in small observational and interview studies in medicine and nursing, frequently this socialisation has been found to be haphazard (Goldie, 2008; Rees & Knight, 2008; Murphy et al., 2009). Despite their importance, interpersonal skills and behaviours are seldom explicitly taught in theory settings. Where there is a conscious attempt to address them they are frequently integrated with communication skills teaching which may make them less obvious and more difficult to grasp (Tsang, 2011)(see for instance Duffy et al., 2004; Association of American Medical Colleges, 2008 where communication and interpersonal skills are referred to simultaneously). In addition, practitioners and teachers in practice are often unaware of the interpersonal skills they demonstrate in practice (van Mook et al., 2009).

Professional education differs from more academic disciplines in that success in the programme usually leads to a professional qualification, a license to practice with real people, clients, patients or users (Ginsburg et al., 2009; van Mook et al., 2009d). The following sections explore the implications of licensure and the complexity of assessment in professional education.

### *2.2.1. License to practice*

Professional education confers a qualification or a license to practice (Eraut, 1994). This may be awarded through completing an academic programme or through licensing exams. Successful completion of professional education separates those who can practice the profession from those who cannot. In this way professional education carries a duty to society to prepare safe and effective practitioners (Broadfoot & Black, 2004; Newton, 2007). This responsibility results in a higher requirement for robust assessment processes than in academic degrees of more theoretical subjects; crucially, the distinction between a passing and failing student must be clear (Newton, 2007). There is a debate in the education literature about

what level of expertise is actually required to be competent or to achieve a competence (Cowan et al., 2005; Alison Evans Consulting, 2008; Knight & Yorke, 2008), but the broad consensus is that it should indicate, at a minimum, that the individual is a safe beginning level practitioner.

Assessment of clinical, or practical, experiences adds another layer of complexity to professional education as it takes place in settings outside the control of the awarding institution. Furthermore, the purpose of assessment in practice settings does not focus solely on the student and assessor, but also on perceived risks to patients or a client group, the public and/or future co-workers (Jinks, 2007). In discussions of the purpose of practice assessment, researchers found that in nursing (Stokes, 2005; Henderson et al., 2006), and physical therapy (Jette et al., 2007) concepts of professionalism and safety became valued by clinical assessors, faculty and students, possibly surpassing the value accorded to achievement of understanding and knowledge.

### *2.2.2. Complex knowledge*

Professional knowledge is complex. In his seminal book on professional knowledge and competence, Eraut (1994) describes several types of knowledge necessary for professional practice; *procedural knowledge, propositional knowledge, practical knowledge, tacit knowledge, craft knowledge, personal knowledge, action knowledge, knowing-that, knowing-how,* and *knowing–in-action*. Some of these are roughly analogous (e.g. knowing-how, craft knowledge and practical knowledge), however it is clear that learners in professional education must accumulate and assimilate a variety of types of knowledge that go beyond what can be taught in books or classes (propositional knowledge) and will develop their own repertoire of how to implement this knowledge (craft knowledge) through experiencing practice and actively learning from that experience (personal knowledge). Because professionals develop their propositional and personal knowledge over time, they may not be aware of what they know (tacit knowledge) or how to articulate it to a learner. The practical component of professional education has an important role in supporting the implementation of propositional knowledge and development of craft and personal knowledge. However, education must be active, simply being in the presence of practitioners does not guarantee development of knowledge in

terms of integrated experience (Yorke, 2005). Assessment in practice therefore must also reflect this complexity and cannot merely assess the easily observable and accessible propositional knowledge. The 'know-how' that learners must develop includes the ability to work with people and assessors must be able to gauge the extent to which the learner has achieved this competence.

### *2.2.3. Working with people*

The nature of professions is to work with people. Professions provide a service and as such have a public face. Increasingly, especially in healthcare, professions must also work with each other (Mann et al., 2005). This means that all professions must develop their students' interpersonal skills alongside other types of propositional knowledge and technical skills. Studies in social work (Bogo et al., 2002), physical therapy (Wolff-Burke, 2006), medicine (Goldie, 2008) and nursing (Walsh et al., 2008) have identified expected (if not articulated) standards of attitude and behaviour. Skills required for working with people have a cognitive element (e.g. propositional knowledge about barriers and facilitators of communication) but also require knowing how to behave in a situation and fulfil expectations about the professional role (Glicken & Merenstein, 2007). Despite the importance of this skill, it has often been ignored in assessment processes: for instance, in a qualitative study of physical therapy clinical instructors' experiences of 'inadequate performance', Hayes and colleagues (1999) found that some clinical instructors witnessed student behaviours they found personally unacceptable, but did not deem the behaviours to be clinically relevant. Reports in social work (Furness & Gilligan, 2004; Finch, 2009) and nursing (Price, 2007) have also found that assessors describe students who satisfy the practice criteria but about whom they feel uneasy. In their book on Success and Failure in Professional Assessment, Ilott and Murphy (1999) report that such students are usually passed as the assessor lacks confidence to assess areas outside the set criteria.

### *2.2.4. Student self-assessment*

The ability to self-assess is an important skill in post-qualification professional practice. To know one's own limits and the ability to identify areas for further development are part of professionalism and safety. Garrigan (1997) suggests that

assessments on professional programmes should include an element of self-assessment in order to develop this skill. However, self-assessment is not always accurate (Eva et al., 2011). In a focus group study of self-assessment in medical students, Rees and Shepherd (2005) asked students' and assessors' opinions on the accuracy of self-assessment. Assessors in the study felt that the students who most needed help overestimated their abilities. Students reported that assessor's expectations of them were too high, leading the assessors to underestimate their abilities. Lauder et al. (2008) asked nursing students to rate their competence in numeracy, hand decontamination and communication, then observed the three skills at 'objective structured clinical examination' (OSCE) stations and found there was little correlation between observed competence and self-assessment of these clinical skills. A growing number of studies question the efficacy of self-assessment tools and challenge the suggestion that introducing self-assessment tools is sufficient (Rees and Shepherd, 2005; Sargeant et al., 2008; Archer, 2010; Finn, 2010). Nevertheless, in a review of the self-assessment literature Eva and Regehr (2008) concluded that self-assessment should be taught rather than assuming students will learn it on their own. They suggested that providing clear and overt external feedback within a safe environment is the key to enabling students to develop skills in assessing themselves accurately.

## 2.3. Healthcare professions

Health and social care professions have a greater requirement for safety and interpersonal skills due to the vulnerability of the people with whom they work. Each practitioner's work can have direct and serious consequences on those in their care. A burgeoning literature in many professions points to the importance of interpersonal skills and development of professionalism. The medical education literature has led the way trying to describe interpersonal and professional skills and identify ways to teach and assess them (reviews and recommendations from: Duffy et al., 2004; Hilton & Slotnick, 2005; Green et al., 2009; Schwartz et al., 2009; Symons et al., 2009; Passi et al., 2010). For medical education in Scotland, Goldie (2008) proposes a way to integrate professionalism into the curriculum and suggests wide-ranging strategies such as structuring practice experiences, developing and supporting critical thinking, teaching students to be self-directed and giving students feedback on all aspects of practice including behaviour. In

recent recommendations from the biennial medical education Ottawa conference, Hodges et al. (2011) suggest that context of practice is important, and that there should be more focus on formative feedback and interpersonal skills within assessment of professionalism. Summarising previous research work they state:

> "Assessment involves characterizing those expectations and measuring the degree to which the profession (be it a subgroup such as students, a whole medical school, a professional practice group, or even the profession as a whole) meets those expectations." (Hodges et al., 2011, p. 361).

Other healthcare professions such as occupational therapy (Ilott, 1996; Knight, 1998; Scheerer, 2003), social work (Regehr et al., 2007; Shapton, 2007; Parker, 2010) and physiotherapy (Hayes et al., 1999; Jette et al., 2007; Dalton et al., 2007) have been conducting their own research and trying to refine their own theoretical positions and assessment techniques. Demonstrating that issues of professionalism are not confined to the silos of individual professions (Hafler, 2011), some researchers have studied a variety of healthcare and other professions (Heggen, 2008; Tsang, 2011). The National Clinical Assessment Service[4] (NCAS) (2009) reports that unprofessional behaviours such as aggression, poor interpersonal communication skills, not learning from mistakes and so on are common across healthcare professions. They further note that perceptions of the person influence assessment with 'likeable' people being seen as charismatic instead of manipulative or independent instead of unable to follow rules. Tsang (2011) defines professionalism as a 'threshold concept', one that is difficult for students to grasp. She, along with the NCAS suggests that referencing professionalism against explicitly stated standards or norms will help students overcome this threshold barrier. While the question of assessing interpersonal skills is of broad interest throughout the healthcare professions, the following section of this literature review examined nursing in particular detail, focussing on the issues of competence, complexity and licensing in relation to the assessment of interpersonal skills in practice.

### *2.3.1. Nursing as an example*

Nurses are one of the largest occupational groups in healthcare. Nurses also have

[4] Assessment body of the National Patient Safety Agency in the UK, associated with the DoH but operating at arm's length.

direct contact with a variety of vulnerable people, their family members and carers. The educational preparation of nurses differs between countries, but the clinical component is usually quite large (30-60%) with practitioners doing the bulk of the clinical teaching and assessment (Luhanga et al., 2008b; Levett-Jones & Lathlean, 2009; Oermann et al., 2009; Warne et al., 2010). Access to sophisticated or complex teaching and assessment strategies is limited for nursing students in many countries, mainly due to the large number of students and the lower level of per-capita government funding compared to other health disciplines (such as medicine or physiotherapy) (Sastry, 2005). Nursing students are rarely taught or assessed using simulated patients, OSCEs or multi-source/360° feedback. Despite positive evidence for assessment by OSCEs (Nicol & Freeth, 1998) the NMC has not explicitly mandated their use, nor have many schools of nursing embraced this assessment strategy in pre-registration programmes (Bradshaw & Merriman, 2008; Oermann et al., 2009). The challenge of teaching clinical nursing is not only the volume of students, but also the variety of clinical areas and required skills, from community nursing with the chronically ill to intensive care nursing in 'high tech' acute care hospitals. The differences in knowledge and technique particular to these diverse settings notwithstanding, interpersonal skills cut across settings and are required in every area where nurses work.

The delivery of nursing education has changed dramatically over the years. Education has moved out of acute hospital settings and into HEIs, and students no longer constitute part of the workforce (Bradshaw & Merriman, 2008) [see 1.2 for context on nursing education in the UK]. Across the globe, nursing students are no longer likely to be young, female and unattached, rather they are likely to be older with families and more complex personal, financial and emotional lives (Katz et al., 2004; Hill et al., 2006; Newton et al., 2009; Warne et al., 2010). These changes have an impact on the socialisation of nursing students into the nursing profession and on unspoken expectations around behaviours and attitudes (Wyatt, 1978; Brackenreg, 2004; Clark, 2004; McGowan, 2004; Shinyashiki et al., 2006). Nursing students also work with and learn from an increasing variety of staff, many of who do not have formal training (McGowan, 2004; Webb & Shakespeare, 2008). In the UK these workers are known as healthcare assistants and have a supportive role in the clinical area, often undertaking tasks delegated by registered nurses.

Increasingly, students have themselves worked as healthcare assistants prior to enrolling on their nursing programme (McKenna et al., 2006). Although healthcare assistants learn on the job and are not socialised into the profession through education, they play an important role in clinical area and may influence students by providing role models for care (White et al., 1993).

Concerns about the health care needs of an aging population and increasing numbers of nurses approaching retirement age (International Centre for Human Resources in Nursing, 2007) are placing great demands on programmes to prepare large numbers of students, thus putting stress on resources both in HEIs and practice settings [see 1.2.1.1]. In the light of these increasing challenges, it is important to ensure that all aspects of nursing education are thoroughly and explicitly taught and assessed.

The NMC has enshrined the responsibility of nurses to support students in the 2008 code "*You must facilitate students and others to develop their competence*" (NMC, 2008 p. 5). Unfortunately the term facilitation makes no reference to assessment, giving critical feedback and responsibilities in relation to failing students. Additionally, as Neary (1997b; 1997a) noted over a decade and a half ago, based on her large interview and questionnaire-based study of nursing students and nurses who assessed students, the roles of teaching and assessment are added to the nurse's role in clinical practice with no reduction in workload or increase in pay to reflect the additional challenges. Despite an increased profile for mentorship, clinical nurses may not be fully aware that they bear the responsibility for teaching and assessing student nurses to the extent of providing half of their education (Duffy, 2003). In effect, fifty percent of nursing education has been devolved to thousands of individuals with varied levels of preparedness and understanding of educational and assessment theories and principles.

Studies have questioned the level of knowledge and sophistication of assessment that this varied group of assessors can provide. Over 100 nurses in Belgium responded to a questionnaire on their mentoring experiences and reported that they found mentorship time consuming and they were unwilling to give students written feedback (Huybrecht et al., 2011). In a Finnish-British literature review,

Jokelainen and colleagues (2011) presented a unified description of what is essential in mentoring students. They identified a lack of preparation and resources to achieve these aims. In the context of a shortage of clinical nursing staff and of faculty, in a qualitative study exploring clinical placements in one American state, Leners and colleagues (2006) reported a shortage of adequately prepared clinical nurse preceptors (nurses who provide direct clinical teaching but not assessment in the US). Using a self-report 'Assessment of Clinical Practice' questionnaire, McCarthy and Murphy (2008) asked 470 Irish preceptors—nurses who had been trained to teach and assess students on a Bachelor's of Nursing programme—what their experience of assessing had been. They found that preceptors had an inconsistent understanding of assessment theory and did not use the assessment tools provided. McCarthy and Murphy commented:

> "to provide preceptorship programmes, and assume that qualified nurses understand the process of assessment is optimistic. …To enable preceptors [to] continue with the assessment process in a more consistent fashion, nurse educators must make the assessment strategies more user-friendly and more transparent for preceptors." (McCarthy & Murphy, 2008, p311)

Similarly in qualitative studies in the UK, students (Andrews et al., 2006) and mentors (Webb & Shakespeare, 2008) identify insufficient mentor preparation. Anecdotally, and in the UK literature, it is clear that nurses frequently believe the HEI will address serious deficits in a student's abilities (Harding & Greig, 1994; Chambers, 1998; Dolan, 2003; Duffy, 2003). In cases where tripartite assessment systems (between the HEI, practice area and student) do not exist, and where support for clinical staff by the HEI is patchy, the integrity of assessment of practical placements is therefore at risk (Clarke et al., 2003; Chapple & Aston, 2004; Hyatt et al., 2008).

This combination of high student numbers with low provision for preparation and support of clinical mentors in the practice setting makes nursing an important discipline in which to examine how attitudes, behaviours and interpersonal skills are assessed in the practice setting.

#### 2.3.1.1. Practice assessment in nursing

Practice learning of student nurses in different countries is assessed in a variety of

ways. In the US, the final responsibility for assessment falls to academic faculty who make use of feedback from clinical supervisors (Tanicala et al., 2011). In Canada & Australia, sessional faculty; registered nurses, sometimes called preceptors, are hired to work with and assess small groups (usually about eight students) on placements, with contributions from staff nurses who work alongside the students (Luhanga et al., 2008b; Newton et al., 2009). In the UK, mentors are clinical nurses who take on the additional duty of working with students and take responsibility for practice teaching and assessment. The terms mentor and preceptor are intermingled in the literature (Yonge et al., 2007), however, for the purposes of this study a *mentor* refers to a clinical staff nurse who has some educational preparation as described in section 1.2.1.2, who is on the 'mentor register' held by each clinical institution (hospital, community service etc.) that provides placements, and who is assigned nursing students (up to a maximum of three) to support and assess throughout the period of the practical placement (NMC, 2008b). The term *mentor* will be used in this Literature Review, when studies of equivalent roles are reviewed, even though some studies may have used different terms for the role.

In the UK, the license to register as a nurse is granted upon successful completion of the academic and clinical programme; unlike many other countries, no additional licensing exam is required. In England, Scotland and Northern Ireland, oversight of practice assessment has been devolved to individual HEIs, with each institution developing its own set of documentation and practices. Although the NMC sets out minimum regulations for achievement (hours in practice, exposure to certain clinical specialities etc.), there are variations in assessment practices. In Wales the 'All Wales Initiative' developed a single practice assessment document that is used by all Welsh HEIs and practice settings throughout the three-year nursing programme (Dolan, 2007). Because so many different nurses are responsible for assessment, it is vital that practice assessment documents are easy to understand, simple to use and assess relevant skills (Calman et al., 2002; Pulsford et al., 2002).

#### 2.3.1.2. Challenges to mentorship in nursing

Mentorship in nursing in the UK faces particular challenges. As the number of

nursing students increases, so does the number of mentors required. Attempting to prepare them all is a challenge, as observed over the study data collection period, during which there was an increase in commissioned student numbers (RCN, 2011). Developments, including instituting a bachelor degree as the minimum educational requirement for entry to the professional register (to become a licensed nurse) in the UK, have seen these numbers fall but they still remain high [see section 1.2.1.1]. Issues that further challenge mentorship include practice assessment documents that change frequently (Bradshaw & Merriman, 2008) and on-going communication problems between HEIs and placement areas (Andrews et al, 2006; Hyatt et al., 2008). To address these problems, a variety of roles and systems to improve links between faculty from HEIs and their counterparts in practice have been trialled (Sharples et al., 2007; Hyatt et al., 2008; NMC & Mitchell 2008).

In order to meet some of these challenges, changes have been made on local and national levels since 2007. The NMC (2009; 2011) has produced student guidance that more explicitly discusses expectations of nursing students, including 'good character' (a requirement for registration as a nurse in the UK). Practice or clinical education facilitator roles have been created to provide more support to mentors in practice (Lambert & Glacken, 2005; Lambert & Glacken, 2006; Jowett & McMullan, 2007; Hyatt et al., 2008) and HEIs are trialling different ways to increase communication with clinical areas (Mallik & Aylott, 2005).

Despite these changes, clinical education in nursing in the UK still requires a one-to-one, face-to-face assessment process between mentor and student. The process is 'continuous', mentors should not assess snapshots of practice or particular skills, but rather the assessment is based on the whole of the mentor's experience working with the student (Scammell & Heaslip, 2009; Tolley et al., 2011b). Providing constructive but negative feedback directly to students is challenging for many (Ilott & Murphy, 1997; Hawe, 2003; Dudek et al., 2005). For nurses—whose role has traditionally been to nurture and support—being asked to challenge, assess and pass judgement can be particularly difficult (Barnard, 2004; Stuart, 2007).

Teaching and assessing in practice requires skill and preparation but also confidence in one's own abilities to practice and to give feedback. In the UK, the majority of mentors are selected from clinically based staff nurses—designated band 5 since 2007 (DoH, 2007) —who are usually the least experienced staff members in terms of both of nursing and mentoring.

In a small study of Scottish nursing mentors commissioned by the NMC, Duffy (2003) popularised the term 'failing to fail'. Considering the challenges and contexts described above, Duffy's qualitative study investigated reasons for traditionally low failure rates in practice when compared to theory, and queried the effectiveness of practice education in producing safe practitioners. One of her main findings was that ill-prepared and ill-supported mentors found it difficult to fail students. Various reasons for 'failing to fail' in healthcare professions have been suggested: in occupational therapy, Ilott and Murphy (1997) explored the negative emotional impact of failing students on assessors and nursing mentors; while Lankshear's (1990) focus group study identified an increased workload as a consequence of poor preparation. Finally, Fraser et al (1997) and Bedford and colleagues (1993) reported that lack of confidence makes it difficult for a mentor to decide to fail a student or to give challenging but constructive feedback (cited in Stuart, 2007). These factors are exacerbated by role conflict that occurs when 'caring' healthcare professionals attempt to incorporate negative or failing summative assessments into their teaching role (Ilott & Murphy, 1999; Fraser et al 1997, Stengelhofen 1993 cited in Stuart, 2007).

In addition to facing clinical pressures, nursing mentors in the UK must also overcome further obstacles. Mentors are not primarily educators, but have varying levels of educational and assessment preparation (Mallik & McGowan, 2007; Hyatt et al., 2008; Myall et al., 2008). They work in isolation, each in their own clinical area, so that even if there is 'team mentorship', (i.e. several nurses support one student), the 'team' often has no reference outside of the particular clinical area, thus developing either a narrow community of practice or none at all (Hall & Harding, 2002; Barnard, 2004). Unlike their academic colleagues who teach classes, most mentors have less experience of supporting a wide variety of students. According to the NMC, a nurse can support a maximum of three students at any one time (NMC, 2008b, p. 31) but, anecdotally and in my experience, most

support fewer and, due to the organisation of placements and academic blocks of study, there could be long gaps between successive students. Coupled with changing practice documents written in 'academic jargon' (Neary, 2001; Pfeil, 2003) mentors may default to norm referencing students (assessing students with respect to one's own sense of norms, comparing them to each other or to previously remembered students) rather than criterion referencing (assessing to standardised criteria) (Chambers, 1998; Redfern et al., 2002; Parker, 2003; Mallik & Hunt, 2007). In the absence of rigorous and consistent mentor preparation, norm referencing means that students are effectively not being assessed through the HEI's documents, but to their particular mentor's set of standards.

### *2.3.2. Assessment in practice*

The challenges of assessment in practice also exist outside the direct UK mentoring context. In a study prompted by an unusually large number of high grades for nursing students' practice assessments in the US, Seldomridge and Walsh (2006) examined both the literature and their own educational practice for explanations. Although clinical preceptors in the US are more closely tied to the university than mentors in the UK, similar problems emerge as they also collaborate with clinical nurses. Seldomridge and Walsh found that clinical nurses were overextended, their teaching role was not officially recognized, poor grades required greater investment of time, and these nurses experienced role conflict. They found that nurses felt unable to give constructive feedback, they may have had unclear expectations for performance and there were differences between practical and college settings in terms of what was valued. In a small qualitative study of novice and experienced Canadian nursing mentors, Scanlan (1996) identified that novice mentors have difficulty failing students; doubting their own judgments and being unwilling to fail students in early placements in order to 'give them a chance' (see also Duffy, 2003). Recently graduated nurses may have a strong identification as 'caring professionals' who want to support but not assess and fail students. Scanlan and colleagues (2001) also found that students were increasingly willing to challenge mentors, especially those who may not have received enough guidance to a) determine safe practice and b) document student progress or problems and c) support the student before assessing a fail, thus further undermining the mentor's confidence. In the field of medical education, Twenge

(2009) also identified an increasing sense of entitlement to education and, compared to previous generations of medical students, an expectation of better grades merely for attending or trying.

Whilst academic assessors may take marking home and select a time conducive to its completion, mentors often try to fit assessment into a busy shift, between prioritising patient care and taking their own (food or rest) breaks. Unlike academic markers, the presence of the student is required for assessment in practice, thus complicating schedules and timing. Student-mentor relationships impact on assessment in a variety of ways, and can lead to either over- or underestimation of the student's clinical capability. Using a critical incident approach Webb and Shakespeare (2008) reported the emotional labour described by both experienced and novice mentors as part of their role. Mentors' emotional investment may result in the perception that the student's success or failure is a reflection of their own skill and teaching (Ilott & Murphy, 1997; Duffy, 2003; Yorke, 2005; Luhanga et al., 2008c). If the mentor perceives that the student does not value their time and effort, this may result in a failure or poor assessment despite having achieved 'success' with clinical skills (Wallace, 2003; Bogo et al., 2006; Jette et al., 2007). Eraut (2003) described 'first impression' syndrome, where even a positive impression can impact on assessment in ways that are difficult to predict (see also Parker, 2003). For instance, a positive first impression may set up high expectations for the placement which may not subsequently be met, leading to a poor assessment overall. In contrast, a different student might respond with increased confidence and engagement and proceed to engage more deeply in the placement and obtain continued positive assessments (Eraut, 1994, p. 178). It is inescapable that practical placement assessment takes place in a social context after a relationship has been formed between the mentor and the student (Parker, 2003). These relationships mean that the interpersonal skills and qualities—of both the mentor and the student—can have an impact on assessment in unpredictable ways.

In addition to other challenges of assessment in practice, two studies of mentors in pre-registration nursing in Scotland (Calman et al., 2002) and Australia (Paliadelis & Cruickshank, 2003) found that mentors did not always use the assessment tools

provided. In England (Neary, 1999) and Wales (Dolan 2003) it was found that if tools were used, they may have been completed merely as a formality for the HEI. These findings suggest that assessment tools in practice should be simple and useful in order to increase their use in practice.

Research in practice-based assessment that focuses on the development or improvement of assessment tools often fails to address the complexity of using the tools or giving feedback. However, qualitative studies such as Cleland et al (2008) and Finch (2009) give an insight into the experience of doing assessment, particularly the challenges in assessing professionalism and interpersonal skills.

#### 2.3.2.1. Challenges in assessment of professionalism and interpersonal skills

Borderline pass or failure rates are much lower for practical work in clinical areas than for academic work (Hunt et al., 2012). Calman and colleagues (2002) surveyed and interviewed staff, and reviewed documentation for all 13 institutions offering nursing studies in Scotland. They found that it was unusual for students to fail on clinical grounds: almost all discontinuations from the programme were on academic grounds. In Watson's (2002) study of the grading (from A to F) of learning contracts, only two out of 284 learning contracts were graded D and none were graded E or F. Figures from the study HEI were difficult to obtain (due both to 'convergence' [section 1.3.1] and complex tracking of students who have interrupted [section 1.3.1.3] and who do not come back), but anecdotally, the study HEI reflects the norm with low levels of clinical fails. As the clinical component has made up 50% of UK pre-registration nursing programmes since the inception of Project 2000, these numbers seem unlikely to reflect true practice achievement, but rather, as Duffy (2003) identified, a failure of clinical mentors to fail students' clinical practice. The fact that the current assessment of nursing students allows students to continue on the programme when they require more support and feedback, or should leave the programme altogether, does not constitute a criticism of nursing mentors. Many researchers have identified obstacles to failing a student in practice.

A qualitative study of medical clinical supervisors identified that a lack of

documentation and knowing what to document, a lack of possibilities for remediation and anticipation that the student would appeal inhibited assessors from reporting unsatisfactory or poor performance (Dudek et al., 2005). In a review of medical education literature Holmboe et al., 2011 concluded that assessors need more training on competency-based medical education and it's assessment in all domains. Hayes et al.'s (1999) mixed method research into clinical instructors in physiotherapy identified 'red flags' for poor performance in three domains: cognitive, unprofessional behaviours and communication. Hayes and colleagues identified that assessors did not have the confidence to use the unprofessional behaviour category (such as failure to accept responsibility, poor commitment to learning, inappropriate personal behaviour and poor work ethics) despite identifying them a third of the time when describing poor or ineffective practice.

Similarly, from Lankshear's 1990 study on mentor perceptions of students in practice to Fitzgerald et al.'s 2010 investigation into the mismatch between mentors' written feedback in practice documents and informal feedback to nursing faculty, nursing research has also reported obstacles to assessment of non-cognitive or clinical skills. Lankshear's (1990) study of UK mentors found that mentors assumed if the student had passed before, they should continue to do so, and that it was difficult to give critical or negative feedback face to face. Fitzgerald and colleagues (2010) found that mentors could give feedback on clinical skills but seemed unable to document or form action plans for development of communication or other interpersonal behaviours. Anonymous feedback to the HEI contained more honest and critical assessment than documents supplied to students. Mentor (assessor) preparation and support, the timing of assessments and feedback, documentation and support from the HEI present challenges to practice assessment. These problems are intensified when it comes to assessing professionalism and interpersonal skills (Ilott & Murphy 1999; Hodges et al., 2011).

Professionalism and interpersonal skills present a teaching and assessment challenge. An Australian review of competency assessment in nursing since 2000 found that:

> "Some of the areas reported as being more difficult to assess include ethics, advocacy and use of research, as well as caring, interpersonal interactions and decision making. Areas related to character or personal attributes have also been flagged as problematic for assessors". (Alison Evans Consulting, 2008, p. 19).

These skills are often related to intrinsic characteristics and may be difficult to observe (Hawkins et al., 2009). Despite these difficulties, as discussed below, researchers in health education have attempted to identify core concepts constituting interpersonal skills.

Some studies have found that mentors, service users and carers value intrinsic personal qualities. In an attempt to define quality care, Attree's grounded theory study (2001) found that patients and relatives valued nurses' interpersonal skills such as: the ability to develop relationships; being kind, concerned and compassionate; having knowledge of the patient as a person. More recently, in focus groups with a range of service users and carers, Griffiths and colleagues (2012, p. 123) found that the focus group participants wanted a '*caring professional attitude'* from nurses saying: "*It is not what they do it is the way that they do it that matters.*" And "*Those old fashioned qualities, they're still really important.*"

Mentors in a variety of healthcare professions also seem to weigh students' personal qualities in their assessment of clinical performance. In a study of comments documented by mentors of Mental Health nursing students, Brown (2000) found that 'good students' were seen as:

> "[…]approachable, 'very caring person', mature, 'confident calm manner', 'caring and thoughtful person', conscientious, helpful, pleasant, friendly, sensitive, understanding, real, open, polite*"* (Brown 2000, p. 413).

Similarly, in a study of pre-registration nursing in the UK, through interviews with 15 mentors, Webb and Shakespeare (2008) found that mentors identified the attributes of a good student as: being enthusiastic; having a positive attitude and being co-operative (e.g. a "*lovely disposition*" p. 567); being confident and assertive (but not over confident or too assertive); and participating in patient care. In physiotherapy, Cross (1998) asked 20 clinicians and 20 academics in the UK, to describe good and bad performance in practice. Although there was variation within groups, Cross (1998) found that academics and clinicians weighted

constructs differently, with clinicians valuing communication, general disposition and commitment most highly. A more recent American study in physical therapy (Jette et al., 2007) supports Cross' findings: clinical instructors included self-directed learning, interpersonal communication, and professional demeanour as positive attributes in their assessments of clinical skill. Examining Canadian social work education, Bogo and colleagues (2006) reported that when field instructors (who have a mentorship-type role) were asked to describe exemplary students they listed personal qualities (such as maturity, initiative, energy, independence, responsiveness to others and commitment) rather than competencies. Though negative behaviours were also often characterised as personal attributes, field instructors were reluctant to define the student by them, instead emphasising positive aspects (Bogo et al., 2006). These studies from various healthcare professions support the idea that assessors in practice might be assessing students' personal attributes rather than competencies defined by the HEI.

Despite widespread expectations of professionalism, there is debate about the innate vs. teachable nature of these qualities and whether professional socialisation constitutes part of the explicitly taught curriculum or the 'hidden curriculum' (the messages faculty unintentionally send out) (Snyder 1970 cited in Rowntree, 1987; van Mook et al., 2009d).

#### 2.3.2.2. Implicit assessment of professionalism and interpersonal skills

Interpersonal skills are difficult to define, and seem to form an implicit part of practice assessment. Qualities valued by a variety of professions are remarkably similar and yet difficult to define (e.g. lovely disposition), these are usually implicitly assessed in the practice setting (Parker, 2009). Furthermore, as discussed in section 2.3.2.1, they are considered innate qualities and assumed to be difficult to teach (Edwards, 2000). The persistent view of the 'good nurse' (Smith & Godfrey, 2002; Wallace, 2003) is that they are a nice person (Lankshear, 1990). Webb and Shakespeare (2008) found that nurses similarly characterised good nursing students as kind and friendly. However, the terms kind and friendly or nice are not always clearly defined, and the perception and importance of personal qualities varies for each individual mentor.

Trying to make these qualities explicit, Jones (2007) found a resource intensive but effective way to achieve measurable changes in students' understanding of communication and interpersonal skills. He audio-recorded nursing student-patient interactions for later play-back to the students. In the same study, other students also found it useful to listen to and read transcripts of their peers' interactions with patients, reporting some increase in understanding of communication and interpersonal skills. The busy climate of the NHS and the competing demands of patients and students on mentors' time are unlikely to disappear, but measures can be taken to make the interpersonal aspects of practical placement assessment more robust.

Clarity in assessment is essential and to the benefit of mentors and students alike. More than 20 years ago, mentors in Lankshear's (1990) study identified that they lacked a means to document 'intangible' aspects like student attitude and interpersonal skills. This gap persists as instead of clearly assessing professionalism and interpersonal skills, many recently developed practice documents fail to distinguish them from clinical skills such as communication or team working [see for instance the All-Wales document (Health Inspectorate Wales 2006)] (Parker, 2003; Sellman, 2007; Bradshaw & Merriman, 2008).

#### 2.3.2.3. Implicit assessment of interpersonal skills impacts upon borderline/struggling students

Implicit assessment is a problem for any student; however, those who 'naturally' have the positive qualities outlined above [section 2.3.2.2] may suffer only in that they receive insufficient explicit positive reward (Scammell & Heaslip, 2009). However, in a pass/fail assessment that leads to certification as a professional, a pass must mean, at the minimum, that the student is indisputably able to take on the role of junior professional (Newton, 2007); this includes the ability to behave professionally.

Students who struggle to pass, who are marginal, and who sit on the borderline present a challenge to professional practice education. Yorke's (2005) review of practice based professional learning identified that generosity in assessment or giving the benefit of the doubt is a common theme across professions, therefore students continue to pass, progressing to the next placement and possibly to

qualification. Interviews with academics, practice supervisors and coordinators in occupational therapy (Ilott & Murphy, 1997), action research with students, academics and practitioners in midwifery (Fraser, 2000), and two studies from social work (Furness & Gilligan, 2004; Finch, 2009) point to complex factors behind assessors' generosity. This tendency is exacerbated where assessment processes are unclear, and assessors in the practice setting feel more comfortable failing students on technical skills and knowledge deficits (Hayes et al., 1999).

However not all students receive the benefit of the doubt, assessment of interpersonal skills is personal and the nature of practice learning usually includes close relationships between assessor and assessed, meaning circumstance or personality clashes may determine whether a student passes or fails (Hrobsky & Kersbergen, 2002; Barnard, 2004). Robust assessment processes should identify what *will* fail a student and how a problem can be improved without having to fail.

Across professions the characteristics of underperforming or struggling students have been identified. Problems in communication, poor attitude towards the programme or place of work, or the inability to self-assess and critique are common themes in the literature. An American record review of failure in an occupational therapy programme (Gutman et al., 1998) identified eight communicative and behavioural characteristics of students who were achieving academically but were unable to engage with patients: (a) rigidity of thinking, (b) discomfort with the ambiguity that accompanies clinical reasoning (c) lack of psychological insight, (d) difficulty interpreting feedback, (e) externalization of responsibility, (f) difficulty learning from mistakes, (g) discomfort with the physical handling of patients, and (h) dependence on external measures for self-esteem. Similarly, a small American qualitative study examined the perceptions of failure of four nurse preceptors who had failed students in a six-year period. 'Red flags' were identified, mostly related to student's attitudes (with some reference to poor clinical skills): the students asked no questions, demonstrated no enthusiasm for nursing, and just seemed to be 'putting in time' (Hrobsky & Kersbergen, 2002).

In nursing in England, Webb and Shakespeare (2008) found that mentors described poor students as the opposite of good students. Similarly Hrobsky and

Kersbergen's (2002) findings indicated that underperforming students: were unenthusiastic, needed to be motivated to learn and displayed an 'inappropriate attitude' (e.g. were unprofessional, did not learn from feedback, were difficult). They gave concrete examples of this behaviour:

> "[…] every time you turned around she was sitting down. No matter what was going on, she would be slouching on the furniture instead of being alert and taking notice of what was going on around here". (mentor in Webb & Shakespeare, 2008, p. 569).

This echoed the views of mentors in Duffy's (2003) grounded theory study of pre-registration nursing students. Mentors identified characteristics of weak students (e.g. poor participation; a lack of interest; poor communication; lack of professional boundaries) and reported that these were often apparent at the beginning of placements (p. 24). These studies with a variety of methodological approaches provide complementary pictures of what is lacking in the professional practice of failing students.

These findings demonstrate that while negative attributes are recognised across disciplines, the concepts themselves are not clearly defined. For instance, it is unclear how little enthusiasm a student must display to be characterised as unenthusiastic. What *is* clear is that detecting and noting attributes of weak, marginal or failing students can be used to identify them early on in their programmes with an aim for remediation. The literature on mentor preparation and clinical learning suggests that this early identification can allow for early supportive feedback and improvement in clinical practice (Eraut, 2003; Scheerer, 2003; Barnard, 2004; Andrews et al., 2006; Price, 2007; van Mook et al., 2009b; Holmboe et al., 2010; Hunt et al., 2012).

However, the notion of 'red flags' and early identification of problems is contested by Diekelmann and McGregor (2003) who argue that these indicators label students who fall outside the 'norm'. The resultant close scrutiny causes them to lose confidence in themselves thus leading to ever-poorer performances. McGregor, who interviewed successful and failing students for her doctoral study (McGregor, 1996; McGregor, 2005) says that labelling students in this way leads to a 'self-fulfilling' prophecy. To counter this risk, nursing education in the UK has been careful not to breach students' confidentiality and has avoided passing on to

the next placement information about students who struggled, so that each mentor can form his or her own opinion (Ball, 2006). It is important to note however that Diekelmann and McGregor do not characterise these struggling students as lacking insight into their own performances—a problem of struggling students reported by assessors in the practice setting (Ilott & Murphy, 1997; Scanlan et al., 2001; Duffy, 2003; Luhanga et al., 2008a; Luhanga et al., 2008c)—but raise an important question about the (lack of) transparency in assessment of personal qualities and the necessity of further examination of this issue.

### *2.3.3. Practice assessment tools*

Prior to examining tools that have a specific interpersonal skills assessment component [section 2.3.3.1], this section examines some theory behind practice assessment tools in nursing and healthcare professions. Limitations of criterion referencing and strategies that are overly prescriptive are discussed. The holistic approach to assessment through 'authentic assessment' is described. Theory relating to practice assessment tools is further explored in the Discussion chapter [section 7.4].

In an attempt to clarify and rationalise the implicit criteria upon which nursing students were being assessed, Bondy (1983) identified (through discussion with co-faculty at her American university) three essential clinical aspects of learning for effective nursing: 1) psychomotor learning (e.g. clinical skill development), 2) affective learning (e.g. professional socialisation) and 3) cognitive learning (e.g. developing a knowledge base) – findings which replicate Bloom's (1956) classic taxonomy of learning domains. Bondy also suggested that assessment should include elements of remediation and learning as students' practice was not clearly divided into 'pass' or 'fail', but existed along continua in all three aspects. Students' experiences in practice are affected by the level of patient dependency, particular illnesses, nursing needs, staffing levels, skill mix and personalities of patients and staff: factors which all complicate assessment of clinical practice (Jacka & Lewin 1987, cited in Brown, 2000).

Assessment strategies themselves have an impact on how students and educators focus their teaching and learning. For example, critics of competencies suggest

that these lead to surface learning (Tiwari et al., 2005). In trying to assess competence without generating detailed lists, it is suggested that what is easily measured and observed is what is assessed: this then becomes what is seen as competence (Cowan et al., 2005). A further concern is that setting 'minimum' achievement levels for practice will discourage students from striving to develop further (Watson et al., 2002).

Alternatively, criterion referencing can be seen as a positive attempt to increase the transparency of the assessment process and get away from measuring students against a perceived spread of normal (norm-referencing) or the mentors' own standards (self-referencing)(Baartman et al., 2007). However attempting to reduce practice—in any profession—to a lists of tasks and behaviours, may miss out on the holistic judgement that has been formed (Tang, 2008). It may be possible to achieve all the separate criteria for competencies without being able to integrate these to form competent practice.

'Authentic assessment' is a holistic approach that tries to capture and assess what is essential (Wiggins, 1990). The approach can be used in academic settings but is suited to practice as it aims not just to monitor student performance but also to improve it. Formulated in various ways, authentic assessment suggests that students (from primary school children to professionals) should be assessed on tasks and aspects related to the world outside the classroom (Hager & Butler, 1996; van der Vleuten & Schuwirth, 2005; Hawkins et al., 2009; Galbraith et al., 2011). Assessment of students in practical placements by definition fits this requirement, however, to be authentic it is suggested that the assessment should try to capture what the learner actually does, not just what they can show when prompted in an assessment situation (Miller, 1990) [see section 7.4].

#### 2.3.3.1. Tools to assess interpersonal skills

Literature relating to the ISP tool at the centre of this study will be examined in section 2.4. Many general practice assessment tools include aspects of interpersonal skills, (Harrop, 1996; Dalton et al., 2009; Parker, 2009) or interpersonal skills form part of assessments of communication or interviewing skills (Duffy et al., 2004; Yule et al., 2008a; Haffling et al., 2011). Four discipline-

specific examples of tools that include an interpersonal skills component will be reviewed here.

In the last decade, discipline-specific tools have been developed for occupational therapy, surgery, physiotherapy, and nursing respectively. These tools assess many areas of the student's or practitioner's practice and include an interpersonal skills component. Using action research, occupational therapists in Australia developed first the SPEF (Student Placement Evaluation Tool) (Allison & Turpin, 2004) then the SPEF-R (Student Placement Evaluation Tool- Revised) (Turpin et al., 2011). These explicitly assess aspects of professionalism and interpersonal skills. The SPEF-R uses a five-point scale: 1. performs unacceptably, 2. performs marginally (fails), 3. performs adequately (passes), 4. performs proficiently, and 5. performs with distinction. Both practice educators (assessors) and students have reported that the structure and clarity of the tool is helpful and that the instructions are clear (Turpin et al., 2011). The SPEF-R is lengthy and assesses many domains relevant only to occupational therapy. It is now a web-based tool (www.spefonline.com), accessible only to subscribing HEIs through licence and cannot be adapted easily for use by other professions.

In the UK, the NOTSS tool (Non-Technical Skills for Surgeons) (Flin et al., 2006; Yule et al., 2008a; Yule et al., 2008b; Yule et al., 2009) was developed to assess the broad non-technical aspects of surgical trainees' and experienced surgeons' performance. Four domains (with three items to rate in each), including communication and teamwork, are assessed on a four point scale where 1=poor, 2= marginal, 3= acceptable and 4= good. Though these domains are broad, the items are specifically related to assessing a surgeon or surgical trainee in a particular encounter and thus cannot be transferred to other settings. The simple tabular layout and concise item descriptors are transferable. In addition to the tool itself there are several pages of supporting documents where a few examples each of 'good' and 'poor' behaviours are given. In a study comparing several tools in surgery, Beard et al., (2011) found that nurses and anaesthetists were able to assess interpersonal skills with the NOTSS and to give formative feedback.

Using a rigorously research-based approach, Dalton and colleagues (2009) working together with physiotherapists in Australia, developed the Assessment of

Physiotherapy Practice (APP) tool. The APP assesses seven domains using 20 items graded on a scale from 0 to 4 where two is a passing grade. Four aspects of professional behaviour and two aspects of communication are assessed [see Figure 1] and the remaining 14 items reflect more general aspects of physiotherapy practice. A 'Global Rating Scale' [see Figure 2] scoring the overall performance is completed only at the summative assessment. The item statements are concise but detailed performance indicators are also provided for each item: this arrangement was positively rated in two field studies (Dalton et al., 2009). However, research with another tool has suggested that assessors discard materials other than the tool itself, particularly in busy clinical settings (Cross et al., 2001). In an innovation, which could guide other assessment tools, the user manual for the APP clearly alerts the assessor to common assessment problems such as the central tendency (that most people tend to rate using the options in the middle) and trying to become aware of one's biases (Dalton et al., 2009, p. 13-14). The professional behaviours assessed in the APP are still specific to physiotherapy but the clarity of the document and guidance could guide development of other professions' assessment tools.

| **Professional Behaviour** | | **Circle one number only** | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Demonstrates an understanding of patient/client rights and consent | 0 | 1 | 2 | 3 | 4 | not assessed |
| 2. | Demonstrates commitment to learning | 0 | 1 | 2 | 3 | 4 | not assessed |
| 3. | Demonstrates ethical, legal & culturally sensitive practice | 0 | 1 | 2 | 3 | 4 | not assessed |
| 4. | Demonstrates teamwork | 0 | 1 | 2 | 3 | 4 | not assessed |
| **Communication** | | | | | | | |
| 5. | Communicates effectively and appropriately - Verbal/non-verbal | 0 | 1 | 2 | 3 | 4 | not assessed |
| 6. | Demonstrates clear and accurate documentation | 0 | 1 | 2 | 3 | 4 | not assessed |

***Figure 1 Part of the APP***
***(reproduced from Griffith University, 2010 p.2)***

In your opinion as a clinical educator, the overall performance of this student in the clinical unit was:

Not adequate ☐ Adequate ☐ Good ☐ Excellent ☐

***Figure 2 The Global Rating Scale from the APP***
***(reproduced from Griffith University, 2010 p.4)***

Finally, a new brief tool has been designed to assess 'snapshots' of nursing students' practice (Tolley et al., 2011a). Of the six points assessed, two specifically ask about the way a student establishes a rapport and communicates with patients

[see Figure 3]. The tool has a binary marking scheme (demonstrated or not demonstrated) and assessors are required to provide evidence to justify their choice. However, as the tool considers only one interaction, it is unlikely to capture the quality of interpersonal skills in other contexts, such as with nursing colleagues or interdisciplinary team members.

**Table 1. Snapshot criteria, episode of care snapshot assessment**

| Assessment criteria | Demonstrated | Not demonstrated | Justifying comments |
|---|---|---|---|
| **1. Establishes a rapport with the service user.**<br>This must include:<br>• Greets service user/carer/relatives and introduces him/herself<br>• Explains the purpose of the interaction and gains consent, where appropriate<br>• Demonstrates comfort, dignity, safety and privacy at all times | | | |
| **2 Demonstrates the use of effective communication skills**<br>This might include, for example:<br>• Uses appropriate verbal and non-verbal communication skills to engage and respond with the service user<br>• Demonstrates empathy with the service user throughout the interaction<br>• Gives time and space for the service user to pose questions, if appropriate | | | |

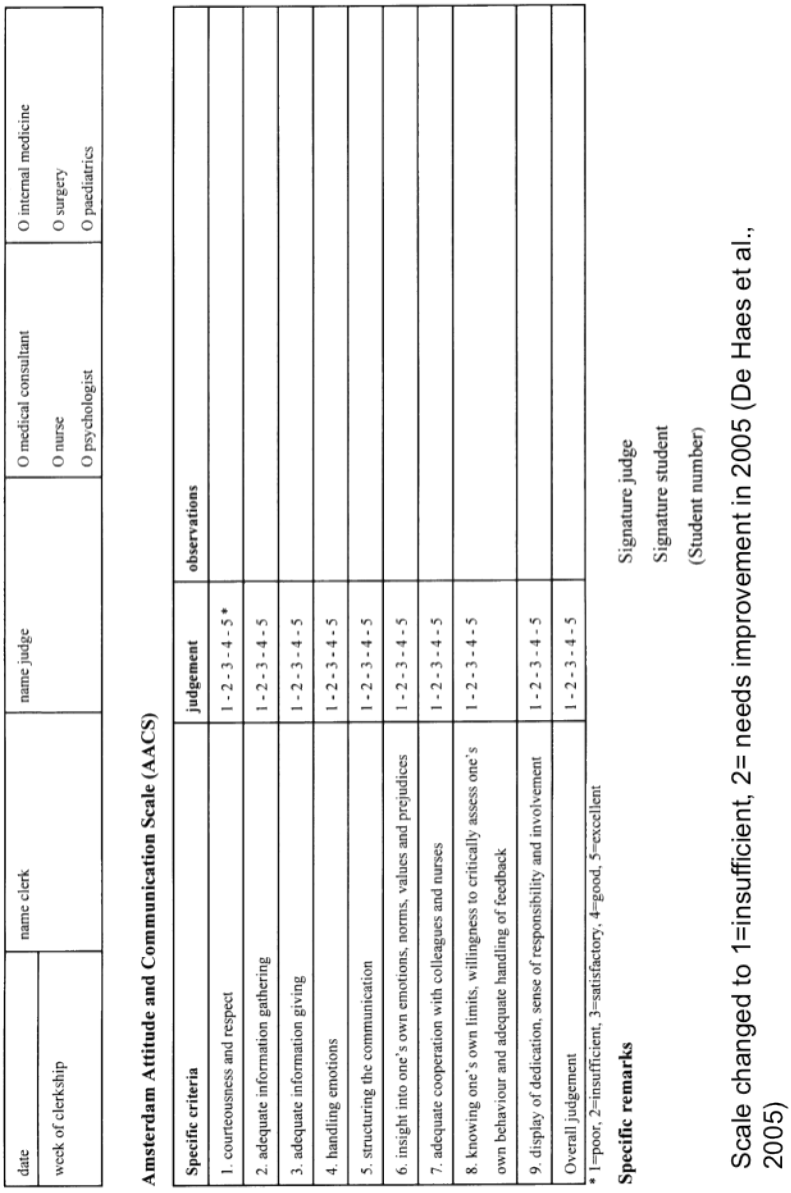
***Figure 3 First two points of the 'Snapshot'***
***(reproduced from Tolley et al., 2011a p. 1140)***

In contrast to the discipline-specific tools which pay some attention to interpersonal skills, several tools have been developed which particularly assess doctors' and medical students' interpersonal and communication skills. These are focused on the medical interview, where doctors gather information and make treatment decisions. These tools tend to focus on communication and rate single encounters (for a review of 15 instruments see Schirmer et al., 2005). Three simple tools that explicitly assess interpersonal skills will be examined in more detail below.

Developed at McGill University, the P-MEX (Professional Mini-Examination) (Cruess et al., 2006) was produced to assess medical students and residents. It assesses 21 aspects of a particular clinical encounter or other learning situation (see Figure 23 in Appendix C) using a 4 point scale where 4= exceeded expectations, 3= met expectations, 2= below expectations and 1= unacceptable. A 'not observed/not applicable' category is also provided. The tool assesses skills in four areas: Doctor-patient relationship skills (active listening, interest and respect etc.), Reflective skills (awareness of limitations, soliciting and accepting feedback

etc.), Time management and Interprofessional relationship skills (maintained boundaries, appearance, addressed gaps in knowledge and skills etc.). Qualitative feedback from assessors and students was positive and suggested the tool was useful in promoting students' self-reflection and raising their awareness of professionalism (Cruess et al., 2006). Snell (2009) suggested that the tool had initiated a change in the teaching strategies around interpersonal skills and professionalism in the medical residency programme. Limitations were the time assessors needed to observe, record and give feedback. The tool is simple and is designed for repeated use over a clinical period to build up a picture of the student's practice. In personal correspondence Cruess (2012) stated that other disciplines have begun to use the P-MEX but he was unsure where or how it was implemented. The P-MEX has been adapted for use in other countries; Tsugawa and colleagues (2009) successfully adapted it for use in Japan. In pre-registration nursing in the UK mentors work with students over shifts: they rarely observe and score individual encounters. The P-MEX adapted to reflect general observations over a period of practice would be more useful in pre-registration nursing.

The Amsterdam Attitude and Communication Scale (AACS) was also designed to assess medical students, however, the assessors could be doctors, nurses or psychologists (de Haes et al., 2001; 2005). The scope of the assessment is broader than the P-MEX in that it assesses nine items such as item 7. '*Adequate cooperation with nurses and colleagues*' and 8. '*Knowing one's own limits, readiness for critical self-assessment, and receptiveness for feedback*' [see



| date | name clerk | name judge | O medical consultant | O internal medicine |
|---|---|---|---|---|
| week of clerkship | | | O nurse | O surgery |
| | | | O psychologist | O paediatrics |

**Amsterdam Attitude and Communication Scale (AACS)**

| Specific criteria | judgement | observations |
|---|---|---|
| 1. courteousness and respect | 1 - 2 - 3 - 4 - 5 * | |
| 2. adequate information gathering | 1 - 2 - 3 - 4 - 5 | |
| 3. adequate information giving | 1 - 2 - 3 - 4 - 5 | |
| 4. handling emotions | 1 - 2 - 3 - 4 - 5 | |
| 5. structuring the communication | 1 - 2 - 3 - 4 - 5 | |
| 6. insight into one's own emotions, norms, values and prejudices | 1 - 2 - 3 - 4 - 5 | |
| 7. adequate cooperation with colleagues and nurses | 1 - 2 - 3 - 4 - 5 | |
| 8. knowing one's own limits, willingness to critically assess one's own behaviour and adequate handling of feedback | 1 - 2 - 3 - 4 - 5 | |
| 9. display of dedication, sense of responsibility and involvement | 1 - 2 - 3 - 4 - 5 | |
| Overall judgement | 1 - 2 - 3 - 4 - 5 | |

* 1=poor, 2=insufficient, 3=satisfactory, 4=good, 5=excellent

**Specific remarks**

Signature judge

Signature student

(Student number)

Scale changed to 1=insufficient, 2= needs improvement in 2005 (De Haes et al., 2005)

Figure 24 in Appendix C for full list]. Items are rated on a 5 point Likert scale where 1('insufficient) and 2 ('needs improvement) are fails and 3-5 ('satisfactory', 'good' and 'excellent') are passes. Interestingly, the initial version tool used the term 'poor' for the first scale point but assessors hesitated to use it (de Haes et al., 2005). The tool is focused around the medical interview and includes items relating to information gathering and information giving, structuring the communication and so on. It also addresses the motivation and dedication of the student. As with the P-MEX and NOTSS discussed above, the tool itself is presented on one-page, however, each item is accompanied by a detailed list of "*desirable and undesirable behaviours*" (de Haes et al., 2005, p. 585), increasing the complexity of using the tool in practice. Although no literature was found to suggest use in other

disciplines, this tool could be adapted and used in other healthcare professions.

The American Council of Emergency Medicine Residency Directors (CORD) (Shayne et al., 2006; LaMantia et al., 2009) has been proactive in developing simple observational assessment tools for particular clinical encounters, such as the 'Standardized Direct Observational Assessment Tool' (SDOT) [see Figure 25 in Appendix C]. This tool was designed to be used across all years of residency (post-graduate) training and requires very little assessor training. There are 26 items (particularly relating to clinical encounters in emergency medicine) with exemplars of anchors for each of the rating scale points: 'needs improvement', 'meets expectations' or 'above expectations'. The grading scale anchors remain the same for all years of residency training (CORD 2004). Six global items follow, including Interpersonal and Communication Skills and Professionalism. The Interpersonal and Communication Skills item carries the descriptor "*that result in effective information exchange and teaming with patients, their families, and other health professionals*" (CORD 2005, p. 2), while the descriptor for Professionalism is "*as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population*" (CORD 2005, p.2). The global items are rated on a five-point scale from 'needs improvement' to 'above expectations'. While a study looking at inter-rater reliability demonstrated poor exact agreement using the tool, it found that for the global items, raters generally agreed on whose performance was marginal or a fail (needs improvement) and who had clearly passed (LaMantia et al., 2009). While the focus of the SDOT is on an individual patient-doctor interaction, as LaMantia and colleagues (2009) identify, global ratings could be influenced by previous encounters with the resident. The global ratings in this tool could easily be modified for pre-registration nursing in which the student is assessed over periods of practice.

In a study looking at how assessors understand and use practice assessment tools, Crossley and colleagues (2011) suggested that whatever the tool, it can be made more rigorous if assessors can relate to the grading scale used. They extensively studied workplace based assessments that used one of three generic tools (the mini-clinical evaluation exercise (mini-CEX), the acute care assessment tool

(ACAT), and the case-based discussion (CBD)). After analysing more than 2000 workplace assessments, they concluded that assessors did not clearly understand scale points referring to expectations for stage of training (such as "*well below/above expectations for this stage of training*" (Crossley et al., 2011, p. 563)) used by the three scales (see 'rating' column in Figure 4). Assessors' confusion decreased the reliability of assessments. The researchers suggested scale points should reflect the question that assessors actually ask themselves: "*Do I trust this trainee*?" (Crossley et al., 2011, p. 562). They tested this theory by using the same three tools but adding a second scale with a different set of anchors for each tool.

| Rating | Mini-CEX clinical anchors | CBD clinical anchors | ACAT clinical anchors |
|---|---|---|---|
| Performed below level expected during Foundation Programme | Demonstrates basic consultation skills, resulting in incomplete history and/or examination findings. Shows limited clinical judgement following encounter | Demonstrates little knowledge and lacks ability to evaluate issues, resulting in only a rudimentary contribution to the management plan | Trainee required frequent supervision to assist in almost all clinical management plans and/or time management |
| Performed at the level expected on completion of Foundation Programme/early Core Training | Demonstrates sound consultation skills, resulting in adequate history and/or examination findings. Shows basic clinical judgement following encounter | Demonstrates some knowledge and limited evaluation of issues, resulting in a limited management plan | Trainee required supervision to assist in some clinical management plans and/or time management |
| Performed at the level expected on completion of Core Training/early higher training | Demonstrates good consultation skills, resulting in a sound history and/or examination findings. Shows solid clinical judgement following encounter consistent with early higher training | Demonstrates satisfactory knowledge and logical evaluation of issues, resulting in an acceptable management plan consistent with early higher training | Supervision and assistance needed for complex cases; competent to run the acute care period with senior support |
| Performed at level expected during higher training | Demonstrates excellent and timely consultation skills, resulting in a comprehensive history and/or examination findings in a complex or difficult situation. Shows good dinical judgement following encounter | Demonstrates detailed knowledge and solid evaluation of issues, resulting in a sound management plan | Very little supervising consultant input needed; competent to run the acute care period with occasional senior support |
| Performed at level expected on completion of higher training | Demonstrates exemplary consultation skills, resulting in a comprehensive history and/or examination findings in a complex or difficult situation. Shows excellent clinical judgement following encounter consistent with completion of higher training | Demonstrates deep up-to-date knowledge and comprehensive evaluation of issues, resulting in an excellent management plan consistent with completion of higher training | Able to practise independently and provide senior supervision for the acute care period |

Mini-CEX = mini clinical evaluation exercise; CBD = case-based discussion; ACAT = acute care assessment tool

***Figure 4 Construct-aligned scales***
***(reproduced from Crossley et al., 2011, p. 564)***

The new scale points had clear behavioural descriptions reflecting increasing clinical independence as training progressed (see Figure 4). Crossley et al. (2011) reported the behaviourally anchored scale demonstrated a higher reliability.

However, as seen in Figure 4, such anchors were tailored to both the clinical setting and year of training, resulting in tools that cannot be used across the student's trajectory. Construct alignment seems to reflect mentors needs but is cumbersome to implement. The lesson could also be that anchors focussing on expectations for point of training should be avoided.

Patient perspectives can provide valuable insights and are being introduced into practice assessment strategies in nursing (Weeley, 2011, personal communication). However, including patient assessments is complex (Calman, 2006). In a grounded theory study of patient perspectives on nursing care, Calman (2006) reported that patients found it difficult to comment on nurses with whom they had ongoing relationships. In her grounded theory study Attree (2001) found that patients had difficulty describing and labelling '*not so good, could be improved*' care (p. 463). Makoul et al. (2007) developed a 15-item instrument for patients to rate physician communication which demonstrated reliability and validity in testing. However, they acknowledge that patient ratings are skewed towards 'excellent': in 950 assessments of 38 physicians, the lowest score was 3.97 out of 5, a full standard deviation below the mean. Thus, while patient perspectives are important, they may not be able to provide an accurate picture for students with poorer practice.

In summary, a variety of discipline-specific tools that include assessment of interpersonal skills have been developed. While they contain an interpersonal skills component, they include other specific aspects of professional practice and cannot easily be transferred to other settings. The medical interview and doctor-patient relationships receive much attention in medical education, which has produced several instruments to assess interpersonal skills. Limitations of such tools are that they may be specific to a particular level of training or have very detailed anchors describing the behaviours to be assessed. To assess interpersonal skills in a practice setting a tool should be clear [see section 2.3.2.2], simple to use, require assessors to provide evidence for their choices and enable them to give students feedback [see section 2.3.3]. Pre-registration nursing has a diversity of placement areas requiring a generic interpersonal skills assessment tool, independent of the particular setting and year on the programme. The ISP [to be

reviewed in section 2.4] is an assessment tool that explicitly assesses students' generic interpersonal skills in all placement experiences and settings.

## 2.4. The Interpersonal Skills Profile

The Interpersonal Skills Profile Tool developed by Knight, an occupational therapy lecturer at the University of Northampton, (Knight, 2003; 1998) is simple to use, and provides a way to assess the intangible interpersonal aspect of a student's performance and the complex skills of working with people. The ISP is can be used in any year of training or placement area thus addressing many of the concerns noted earlier in the Literature Review [particularly sections 2.3.1.1, 2.3.2 and 2.3.3]. The ISP attempts to explicitly assess students' interpersonal skills using criterion referencing, rather than norm referencing based on the mentor's personal experiences [see section 2.3.1.2 p. 35]. The tool may also make it clear to mentors and students alike that nurses have a sense of 'safe practice' and competence, which requires identification and discussion. The statements used as items in the ISP were based on comments drawn from assessors' reports of students in occupational therapy. In the original version there were 40 statements and four grading options: fail, pass, merit and distinction. The original aim of the tool was to allow for a student's skill as a practitioner to contribute to the student's degree classification (Knight, 1998). The tool has since been used in other settings. A web search revealed that at least five other HEIs were using the ISP in a variety of health profession programmes in the UK. However, as not all HEIs publish their practice assessment documents online and the name of the tool may have been considerably altered, a search for 'interpersonal skills profile' may not have found all those in use.

The version used in this study, which was adapted by the study HEI, had 39[5] broad statements in the ISP spanning interpersonal skills, professionalism and engagement with the learning process [For full tool see Appendix A p. 255]. These were 'graded' (although this did not contribute to the degree classification). The grades were 'fail',' pass', 'good' and 'excellent' with three areas where some items

[5] The original ISP had an additional item '*makes effective use of opportunities and resources*' (Knight 1998 p. 319) that was dropped from the study HEI's version.

were graded differently, reflecting lower expectations of students in first year than in second and third years [see fuller explanation in section 11.1 in Appendix B]. For instance, statement eight '*Needs to take responsibility appropriate for this level*' is graded 'pass' in first year and 'fail' in years two and three. In this thesis these items (8 through 13) are termed 'borderline' items in line with terminology in use at the study HEI. There were similar dual grading sections between 'pass' and 'good' (e.g. statement 25 '*identifies own learning needs*'), and 'good' and 'excellent' (e.g. statement 35 '*shows a mature understanding*'). ISP assessors were asked to select five statements, which most closely described the performance of the student. Innovative features of the ISP version studied, were that the assessor was also asked to provide written evidence for the selection of each statement and students were asked to write a self-assessment, adding to the formative aspect of the tool.

Personal attributes and communication skills clearly influence the assessment of learners in the practice setting [see section 2.3.2.3], however, mostly as part of the hidden curriculum (Hilton & Slotnick, 2005) [section 2.3.2.2]. The ISP aims to make explicit this important aspect of assessment. The ISP is also relatively easy to use (a single page including instructions), perhaps increasing the chances it will be used by busy mentors in practice (Neary, 1999; Calman et al., 2002; Dolan, 2003). The ISP is currently in use in several UK HEIs, both in nursing and in other healthcare professions (e.g. occupational therapy, paramedics), either in its entirety or in an adapted form. Therefore, evaluation of how it is actually used in practice can shed light on an important area of practical assessment of pre-registration nursing students in the UK. Some of these ideas may also prove useful across other health and non-health related professions that have a practice component.

Despite widespread adoption, no research has been published on the ISP since Knight's original papers (Knight, 2003; 1998). This means there is no publically available analysis of its reliability or other aspects of its performance and use. The absence of published studies clearly identifies a significant gap in the literature, which this study of the ISP's use in clinical practice will partially address. The absence of published studies also increases the importance of one unpublished

study, which will be described in the next section. Subsequently, section 2.5 will examine why process evaluations of the 'black box' of assessments may be more important than studies of reliability and validity – and certainly are vital to complement studies of reliability.

### *2.4.1. A web-based survey of the ISP*

During the course of this study, an unpublished web-survey examining the whole practice assessment document introduced by the study HEI in 2007 (including the ISP [see Appendix B]) was completed by mentors, students and faculty to support ongoing local refinement of practice-based assessments (Weeley et al., 2009). I was involved in setting up the online questionnaire, which was developed from responses in a preparatory study in which a student, faculty member and mentor from each field (Adult, Child, Mental Health and Learning Disability) had been interviewed using a semi-structured questionnaire. The final questionnaire included six questions specifically related to the ISP, while other parts of the questionnaire elicited demographic information and reactions to other aspects of practice assessment, such as performance criteria, cluster skills, the student portfolio and questions on the general user friendliness of the document. The questionnaire was completed by students, mentors and faculty.

The web-based questionnaire had a low response rate, particularly from mentors [estimated rates as precise numbers were not available were: 84% faculty, 21% students and 6.5% mentors]. However, as a guide, the findings from this study suggest that all groups were satisfied with the ISP [see Table 1]. The majority of respondents in each group agreed or strongly agreed that the ISP was more effective than other parts of the documentation. Little reference was made to the ISP in the free text comments, thus supporting the notion that there were fewer perceived problems with the ISP than with other aspects of the practice assessment document, which received lower ratings (such as cluster skills assessment). As students were not interviewed for the study reported in this thesis [see limitations section 8.1.3], the written comments students made on the online survey will be briefly addressed below.

S=student (n=256), M=mentor (n=97), F=Faculty (n=63)

| % Agree or strongly agree with the statement | *S %* | *M %* | *F %* |
|---|---|---|---|
| The ISP provides immediate feedback for personal/professional development | *68.5* | *73.0* | *79.4* |
| The ISP *identifies areas for improvement* | *76.9* | *82.1* | *80.9* |
| The comments are effective in measuring professional attributes | *66.7* | *78.9* | *79.0* |
| The fine grading aspect (fail/pass/good/excellent) reflects levels of achievement in interpersonal skills | *67.9* | *79.0* | *78.2* |
| The guida*nce for completing the ISP is clear* | *67.1* | *72.1* | *77.8* |
| There is an appropriate number of comments | *74.2* | *78.7* | *71.0* |

***Table 1 Questions on satisfaction with ISP (from Weeley et al., 2009)***

Students' written comments suggested those who made use of the free text space were unhappy with the overall assessment document, particularly with the practice criteria and the amount of time the whole assessment took. However, a few voiced opinions specifically about the ISP [ten out of 143 comments made] and these were generally more negative than indicated by the Likert-scale responses to the questionnaire (where two thirds or more students agreed or strongly agreed with the positively worded statements in Table 1). A few students thought that it would be better for mentors to generate their own comments to avoid 'pigeon-holing' students, others thought that it was repetitive (the ISP is done formatively and summatively in each module, which could mean many times by the same mentor if the student has a base placement over three years [see section 1.2.1]). There were some comments on the formatting, one student did not like the fails at the top of the page, and another thought there was not enough space to write comments. The issue of subjectivity [see section 5.2.1.1] was raised in three comments. For instance, this student noted variability in mentors' assessments

> I think it's too open to personal choice as some mentors want you to do extra work before they sign your book while others will sign it without checking if you have done everything. You can also have mentors who will grade you as excellent for everything and others who will just pass you!!

However, one student particularly liked the document saying

> I like the levels of achievement [ISP] as it shows I am working well and above the level.

Students are right to express concerns and should be listened to [see sections 5.5.2.1.2 and 7.6 for further discussion of bias], however, Calman and colleagues (2002) found in their review of practice education in Scotland, that students were

worried about bias in all the tools studied and concluded that no tool will be seen positively by all users.

## 2.5. Inside the black box of assessment tools

Assessment tools are complex instruments that are used in a variety of settings by many different assessors [see section 2.3.3.1]. Following an extensive literature review, and based on their own considerable research experience in the field, van der Vleuten and colleagues (2010) identified that the validity of a tool used in the workplace was related to the user rather than to implicit features of the tool. They suggest that strategies from qualitative research, such as investigation into the credibility and transferability of the tool should be investigated. In another literature review from the same team, Govaerts and colleagues (2012) suggested that rater differences are fairly resistant to training or providing more standardised and detailed assessment tools.

The complexity of tools to assess practice and interpersonal skills in practice means that psychometric measures of reliability and validity do not address the assessment tools' use in practice. Generalisability theory is a statistical approach to dealing with non-random variance (such as stringency of assessors) in establishing reliability and validity of assessment tools. This quantitative approach is used for evaluation of well known and established tools. For instance, Beard et al., (2011) used it to evaluate three tools in surgical skills assessment and Crossley and colleagues (2011) used it to compare three assessment tools in medical education. However, statistical information does not present a complete picture of assessment tools and their use in practice. The quantitative approach provides figures, but the way in which a tool works remains hidden inside the 'black box' of assessment processes. As Govaerts et al. (2011) suggest, this limits meaningful understanding of workplace-based assessment. Furthermore, it takes insufficient account of assessment contexts (Yorke, 2011).

Realistic Evaluation (Pawson & Tilley, 1997) [see section 3.3] is a research methodology that can provide a differently focused approach to assessment tool

evaluation. As outlined in the following Methodology chapter, Realistic Evaluation was used to open the 'black box' and explore the mechanisms triggered by the ISP.

## 2.6. Research questions

The Literature Review covered professional education in general, and health professions in particular, focussing on the example of nursing education. It was established that interpersonal and professional skills are frequently assessed, but this is rarely explicit. A gap in the literature was identified concerning how to support clear and constructive assessment of interpersonal skills. Specifically there is also a gap in our understanding of how the interpersonal skills of nursing students in the UK are assessed by mentors in the practice setting. There is also evidence to suggest interpersonal skills *are* informally assessed alongside clinical skills (Hayes et al., 1999; Edwards & Chapman, 2001; Knight, 2003; Pfeil, 2003; Regehr et al., 2007; van Mook et al., 2009b; Regehr et al., 2011). The ISP provides a formal mechanism to assess interpersonal and professional aspects of performance, but is under-researched. This study sought to explore its use by mentors and nursing students in a wide variety of clinical placements associated with one large faculty of health. Informed by a Realistic Evaluation approach [see Methodology, section 3.3], this study examined how the ISP was used in placement settings and the ways in which it may or may not work.

The primary research question was:

**How is a tool designed to assess the interpersonal skills of pre-registration nursing students used in practice?**

Secondary research questions were shaped by the selected methodology, Realistic Evaluation [section 3.3] *viz*:

- What are the contexts which inhibit or enable the assessment of interpersonal skills in practice?
- Through what mechanisms does a tool to assess interpersonal skills facilitate their assessment in practice
- What are the outcomes of using the interpersonal skills profile?

# 3. Methodology

The nature of the research questions should influence the methodology and methods used to collect data (Thorne et al., 2002; Probert, 2006). The central question in this study was 'How is a tool designed to assess the interpersonal skills of pre-registration nursing students used in practice?' This placed the study within the field of evaluation research [section 3.1]. The specific evaluation methodology selected was Realistic Evaluation (Pawson & Tilley, 1997) [section 3.3] largely because, at its heart, Realistic Evaluation asks the question "*what works for whom in what circumstances?*" (Pawson & Tilley, 1997 p. 85). Thus there was good alignment between the central focus of Realistic Evaluation and this study's primary research question. The secondary research questions [see p. 59] were subsequently shaped by the selection of Realistic Evaluation.

The philosophical perspective of Realistic Evaluation is critical realism, which is reviewed in section 3.2. Section 3.5 provides an overview of the (qualitative, mixed methods) study design, while the research participants are described in section 3.6. Section 3.7 addresses research ethics in relation to this study and section 3.4 discusses 'mixing methods'. The data collection techniques and processes used in this study are reviewed in section 3.8, while section 3.9 describes the data analysis. Section 3.10 focuses on reflexivity and insider research.

## 3.1. Evaluation research

Educational programmes have been evaluated ever since public funding has gone into education. In their review of the history of educational evaluation, Kellaghan and Stufflebeam (2003) suggested that the initial focus was on quantitative enquiry and standardised testing, and only recently have broader aspects of education including social constraints and contextual factors been included. Evaluation that departs from the positivist model of testing and quantifying may be said to be illuminative, trying to shed light on the programme or tool being studied (Burden, 1998). This study belongs to the more recent, illuminative tradition. There are many approaches to evaluation research (Marks et al., 1999; Kellaghan & Stufflebeam 2003). The particular approach selected for this study

was Realistic Evaluation (Pawson & Tilley, 1997) [section 3.3].

The research questions for this study focused on the use of an assessment tool, the Interpersonal Skills Profile (ISP) to assess pre-registration nursing students' interpersonal and professional skills in clinical environments [see section 2.6]. The focus was on what practitioners thought of the ISP and how they used it, rather than on the psychometric properties of this tool, inter-rater reliability and validity (Martimianakis et al., 2009) [see section 2.5]. Pawson and Tilley state: "*Programs work by introducing new ideas and/or resources into an existing set of social relationships*" (1997, p. 70). This study evaluated a tool which may have introduced ideas about what mentors could legitimately assess and how.

In line with the idea of 'piecemeal' versus grand social change (Pawson & Tilley, 1997, p. 76), this study did not attempt to examine or propose solutions to on-going issues in the wider context within which assessment of pre-registration nursing students took place (pressures of time (Knight, 2006), increasing student numbers (Hutchings et al., 2005; RCN, 2011) and so on) but evaluated how this tool might have operated *within* this set of circumstances.

Realistic Evaluation [section 3.3] is a critical realist methodology [section 3.2], which guided the selection and use of research methods [section 3.4] data collection [sections 3.8 and 3.8.2] and analysis [section 3.9]. However, Pawson and Tilly's exposition of Realistic Evaluation, through being 'whole-heartedly pluralist' [see sections 3.4 and 4.1], offers little guidance on data collection and data analysis procedures, leaving researchers to draw from pertinent research approaches for the evaluation context (Tolson et al., 2007). Consequently, two other research approaches influenced the study methods. Firstly, Appreciative Inquiry [section 3.8.1.2] was used to inform the approach to semi-structured interviewing. Secondly, Interpretive Description guided the analysis of interview data [section 3.9.1].

Critical realist academics Mark and colleagues (1999) present a useful classification of evaluation studies grounded in critical realist thinking. From this perspective the fundamental purpose of evaluation is 'assisted sense-making':

> *"…the field of evaluation has been developed to assist and extend natural*

> *human abilities to observe, understand, and make judgments about policies, programs, and other objects of evaluation"* (Mark et al., 1999, p.182).

Mark and colleagues argue that in order to assist natural sense-making, evaluation should be rigorous and guided by methodology. Rigorous evaluators identify the main purpose of their evaluation and then decide on the mode of inquiry suited to it (description, classification, causal analysis, values inquiry). Although Mark and colleagues are referring to evaluation of social programmes or policies, their criteria can be applied to this study by regarding assessment of interpersonal skills using the ISP as a 'programme': the object of evaluation. The purpose of this evaluation was twofold: for programme improvement through formative feedback (Scriven 1967 cited in Mark et al. 1999) and for broader knowledge development.

Modes of inquiry should be linked to the purpose of an evaluation. This study had three purposes linked to various methods:

a) Descriptive – observing and recording processes and outcomes [see contexts sections 5.2.1, 5.3.1, 5.4.1 and 5.5.1] through interviewing [section 3.8.1] and documentary analysis [section 3.8.2];
b) Causal analysis – probing mechanisms and estimating effects [see data analysis sections 3.9, 4.2.1 and mechanisms sections 5.2.2, 5.3.2, 5.4.2 and 5.5.2];
c) Values inquiry – identifying the positions of stakeholders; mentors, Education Champions (ECs) and Practice Education Facilitators (PEFs) [through Appreciative interviewing 3.8.1.2].

These purposes and modes of inquiry were not separate or mutually exclusive, but identification at the outset meant they guided data collection, analysis and reporting leading to a multi-method design [see section 3.4].

As described in section 2.6, the study examined how mentors actually used the ISP in practice; specifically:

- What contexts inhibited or enabled the assessment of interpersonal skills in practice?
- Through what mechanisms did the ISP facilitate assessment in practice?
- What were the outcomes of using the interpersonal skills profile?

Thus, this evaluation study developed knowledge in the field of practice

assessment and provided developmental feedback to the study HEI.

### *3.1.1. Methodology and philosophy*

Some researchers believe that the philosophy underlying their research process should be explicated and their own views raised to the surface and critically examined (Wilson & McCormack, 2006). Being self-aware reduces unseen influences and can make aspects of the research clear to both the researcher and readers of the research. By clarifying the philosophical perspective it is easier to: identify the language being used; understand what stance was taken, why decisions were made, and evaluate them along with any findings (often seen as the factual meat of research) (Morse & Field, 1995) [see section 3.10.1]. In addition, the same methods (interview, survey, etc.) can be used for a variety of purposes and implemented in myriad ways depending upon the philosophical position of the researcher. Researchers lacking a clear methodological stance may choose their methods inappropriately, and/or mix them in ways that do not address contradictions or tensions in the data (Greene & Caracelli, 2003).

In this study, a *method* was defined as a way to effect parts of the research process, for instance, data collection (interviewing) or analysis (categorising). Methods should be aligned with the selected methodology, but are not synonymous with a particular methodology (Thorne et al., 2004; Rolfe, 2006a; Clough & Nutbrown, 2007). *Methodology* at its most fundamental then relates to how research questions are organised and articulated (Clough & Nutbrown, 2007, p. 32). This study was philosophically underpinned by critical realism, and the methodological approach was Realistic Evaluation.

## 3.2. Critical Realism

There are several realist schools of philosophy, but British philosopher Roy Bhaskar initially coined the term 'critical realism' within an examination of the philosophy of science (Bhaskar, 1998a). His key idea was that in most 'traditional' science, discovering universal laws (gravity, magnetic fields etc.) happened in the artificially closed systems of scientific experiment. Within the positivist paradigm, where only what is observed exists, any contiguous findings were held to be causal. However, the number of scientific findings that can be uncovered in closed

systems is limited. Bhaskar reconceived scientific knowledge as a transitive (changing) realm that attempted to uncover laws (mechanisms) at work in an intransitive (unchanging) realm that exists independently of our knowing about it. He posited a stratified ontology (world, reality) that relates to different levels of human epistemology (knowledge of the world or reality) [see Figure 5 below].

On some fundamental level, the world (gravity, trees, the stars etc.) exists regardless of being interpreted or experienced by human consciousness; critical realists call this the realm of the *real*, a stable or 'intransitive' dimension (McEvoy & Richards, 2006). Relativism, then, is accounted for by how we describe or make assumptions about the *real*. This 'transitive' reality itself has two levels. The *actual*, in which *real* objects and/or concepts are located in space and time but may not themselves be observed or experienced, while the *empirical* is the level at which we perceive, value and classify what we can know of the *actual*. Thus, as Lipscomb (2008) states, the world we apprehend is conceived of as contingent and contextual, and includes theory and values incorporating theories about the *real*. Social phenomena are open systems with innumerable intersecting and interacting factors which influence each other (Archer, 1998; Clark et al., 2008). In later works, Bhaskar moved beyond the physical sciences to outline his conception of the social sciences (Bhaskar, 1998b). In studying social sciences, one must attempt to identify the intransitive elements and the mechanisms influencing perceptions and behaviour in particular contexts. In social sciences there is tension between regarding the intransitive as agency (residing in the individual) versus structure (social and organisational norms) (Archer, 1998).

| | Domain of the real | Domain of the actual | Domain of the empirical |
|---|---|---|---|
| Mechanisms | ✓ | | |
| Events | ✓ | ✓ | |
| Experiences | ✓ | ✓ | ✓ |

***Figure 5 Realist domains and objects of knowledge (adapted from Lipscomb 2008, p. 41)***

Epistemologically, critical realists state that knowledge is generated at an *empirical* level, through experience (research and observation and so on), and then attempts

are made to theorise or discern *actual* knowing. *Actual* knowledge is of events that occur in space and time, and is thus broader than what is observed *empirically.* What is observed may be a result of several mechanisms *actually* operating in concert or contrary to each other, only some of which may be known to us [see Figure 6 below]. The *real* is even more difficult to know as knowing is always mediated by human perception, culture and questions (Kaboub, 2001), but what can be discerned from the real are the mechanisms by which the real acts on the other domains. Realistic Evaluation uses this philosophy to suggest that the researcher must look for mechanisms (which may or may not have been triggered) in the data that we can perceive.

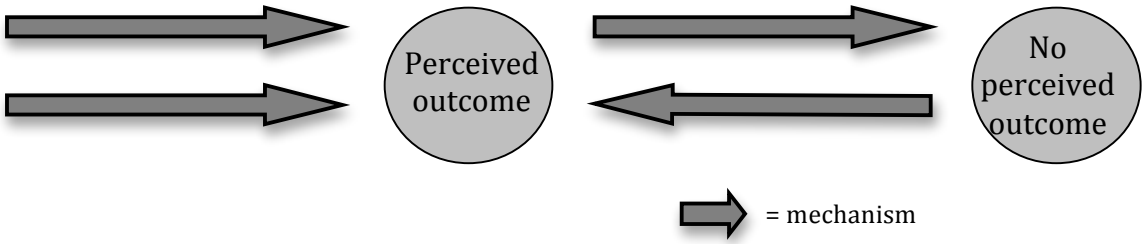



***Figure 6 Mechanisms working together or counter to each other***

Critical realists find a 'middle way' between the philosophical poles of an atomistic or deterministic society. The emergent properties (structures) of a society are the generative mechanisms that shape individuals, who in turn shape these structures. Therefore individuals (agents) act upon society and influence structures, which in turn act on individuals and influence their agency. In doing research to identify generative mechanisms we have to look at what influences the choices that people make (context) and how those mechanisms are enacted, or not (outcomes). In his down-to-earth discussion of critical realism as applied to social work, Houston (2001) points out that mechanisms are not 'hard predictions' but tendencies, and therefore the focus of critical realism is to understand and explain those tendencies (p. 850).

## 3.3. Realistic Evaluation

This section reviews Realistic Evaluation: the main approach is outlined and strengths and weaknesses of the approach discussed. Justification for the use of

Realistic Evaluation is addressed in sections 3.3.2 and 2.5. The use of Realistic Evaluation in Healthcare and Education research is reviewed in section 3.3.4.

### *3.3.1. Overview of Realistic Evaluation*

Realistic Evaluation (also referred to as Realist Evaluation) is a research approach developed by Pawson and Tilley (2004; 1997) and is based in the philosophy of critical realism (Archer, 1998) [see section 3.2]. As evaluation researchers, Pawson and Tilley were aware that large-scale evaluations often presented inconclusive findings, and repeated evaluations came to contradictory conclusions. Rather than discarding prior studies as methodologically flawed, or deeming the intervention to be useless, they noticed that on closer examination, a subsection of the study population either particularly benefited, or did not benefit from an intervention. Pawson and Tilley's insight was to link the evaluation to the context in which it was conducted and look at what mechanism or combination of mechanisms [see Figure 6, p. 65] may have contributed towards observed outcomes.

Mechanisms [see section 3.2, Figure 6] in Realistic Evaluation have a particular meaning relating to the concept of cause and effect. In line with critical realist thinking, Pawson and Tilley talk of 'generative' causation [see section 3.3.3], rather than the successionist theory of causation often identified in positivist approaches to research (Pawson & Tilley, 1996; Archer, 1998; Bhaskar, 1998a). Successionist causation refers to the widely held notion that if X precedes Y and Y happens after X then X causes Y (or in quasi-experimental designs, X is correlated with Y). To discern a relationship between X and Y, researchers try to keep the context constant, or rule it out altogether using techniques, such as, randomisation. Realists critique this approach saying it doesn't hold for the 'real world' where context cannot be ignored. Instead realists posit research methods to identify generative causation. Generative views of causation consider that context is integral to how a mechanism works. For example, McLeroy and colleagues ask, would we expect the identical health promotion strategy on quitting smoking to work with both 15 and 45 year olds? (McLeroy et al., 1988) Realist researchers look for Z which tends to happen when Y is instigated in X context, whist still noting that in context $X_1$, even if Y is triggered, Z does not occur. With this view of causation in mind, the aim of Realistic Evaluation research is to identify

Context +Mechanism = Outcome (CMO)

groupings from the data (Pawson & Tilley, 1997, p. 57-63). This formula can then be applied to evaluation of a wide range of programmes and tools.

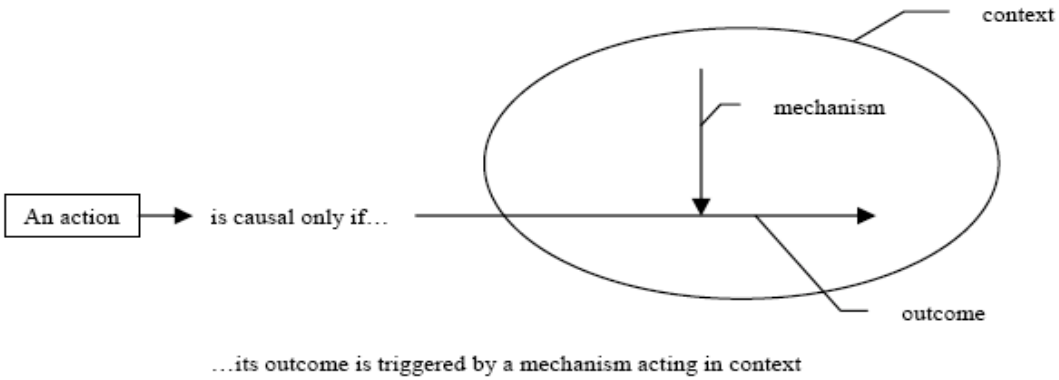



***Figure 7 Generative causation***
***(adapted from Pawson & Tilley, 1997, p. 58)***

The C+M=O model allows for the accommodation of the particular which, intuitively, we know to be important; without losing an ability to apply knowledge to other settings. The model does not descend into a relativistic zero sum game, where every intervention is as good as any other—because the evaluator's role is to assess evidence and make decisions—but the model can acknowledge the richness of the individual and social experience (Mark et al., 1999), incorporating that into their evaluations. The Realistic Evaluation approach does not provide a detailed research design but rather frames evaluation questions, e.g. what is it about the ISP that might produce change? For instance, what aspects (e.g. providing evidence), subgroups (e.g. junior mentors) and types of placement (short or long) might benefit most? [see Discussion section 7.4 ]

### *3.3.2. Applied qualitative research*

The pragmatic grounding (Robson, 2002) of Realistic Evaluation lends itself to research in education and nursing [see section 3.3.4 for examples], fields that are both academic *and* professional (Shaw, 2006). As it is not prescriptive in defining methods to be used (Kazi, 2003), Realistic Evaluation allows the researcher to select the most relevant strategies.

The dominant data collection method for this study was semi-structured

interviewing [3.8.1] which sits in the qualitative paradigm (Fetterman, 1988). Qualitative research is by necessity located in the particular context in which it was conducted, which is frequently cited as a limitation in published papers as authors conclude that 'this study cannot be generalised to other settings' (Payne & Williams, 2005). Indeed, Rolfe (2006b) calls for all qualitative research to be published with a reflexive diary in order to provide a possibility of transferring any findings. This solution is both cumbersome and impractical (how would these diaries be evaluated? How much reflection should be included?) and indeed misses the point of the usefulness to others of qualitative research. Rolfe and many qualitative researchers do their hard work a disservice by ruling out any broader applicability.

Once qualitative research is published and read, readers use the criterion of transferability (Graneheim & Lundman, 2004), where readers transform and interpret the data, relating it to their own context (Sandelowski & Barroso, 2003). However, without a framework for identifying what it is about the research being evaluated that works in another setting, this process is haphazard (Emden & Sandelowski, 1999; 1998). The CMO configurations identified in Realistic Evaluation [see Figure 13, p. 110] provide such a framework and seem to reflect the aims of qualitative researchers implicit in Rice and Ezzy's claim that:

> "… qualitative researchers are interested in the applicability of their findings, based on how the nature and processes involved in experiences generalize" (1999 cited in Fossey et al., 2002, p. 730)

Payne and Williams (2005) term these modest generalisations '*moderatum*', acknowledging that they are open to change due to subsequent research and research findings. Realistic Evaluation puts the generalisability of the context-bound at the heart of its research approach and through analysing descriptive data into context, mechanism and outcome, allows researchers to construct their studies with transferability of ideas abstracted from the data in mind from the outset (Pawson & Tilley, 1997, p. 120; Byng et al., 2005; Dickinson, 2006).

### *3.3.3. Generalisation*

As outlined above [section 3.3.1], Pawson and Tilley present a particular view of the generalisability of research findings, be they from quantitative or qualitative data. In Realistic Evaluation, the researcher may start with hypotheses on possible

mechanisms that come both from the wider literature—sometimes referred to as 'surfacing mechanisms' (Pawson et al., 2004; Gilmour, 2008)—and from their own experience of the setting or intervention being researched [see section 3.10.1 for the theorised contexts and mechanisms of this study]. Although context is vital, what is important in conducting the study is the *identification of factors in the context*, which might facilitate or inhibit a mechanism and lead to a particular outcome (or not). This means that elements of the context are identified along with the generative mechanisms, and it is argued that these can then be transferred to other contexts.

Another way that concepts can be generalised is through 'cumulation' (Pawson & Tilley, 1997, p. 235) where evaluations build upon each other [see Data Analysis, section 4.2]. In this way small scale and local evaluations can provide both valuable specific information and can also be used to form part of a larger picture of evaluation around a topic. Importantly, as mechanisms may work on several levels, evaluations can cumulate either within similar settings or across diverse settings looking at similar questions (e.g. this study may be of interest to others assessing nursing students in practice, and/or to those looking at assessing interpersonal skills in some other context).

#### 3.3.3.1. Critique of Critical Realism and Realistic Evaluation

Critical realism has attracted support and critique. The critique has mostly centred on its ontology. Some constructivists reject a position that regards the intransitive realm as existing outside of the human ability to sense and interpret (Brown, 2009) whilst others claim that it is positivism in disguise: for example, critical realism is still claiming there is a single view out there to be discovered (Wuisman, 2005) and has its own hegemonic agenda (Cruickshank, 2004) which actually embraces dualism between mind (knowledge of the world) and body (experience of it) (Willmott, 2005). While not rejecting the philosophy, Downward and colleagues (2002) suggest that critical realism unnecessarily rejects inductive research methods and theorise ways in which methodologies such as grounded theory can be accommodated. While accepting critical realism as a potentially inspirational way to guide thinking about research questions, Kemp (2005) claims ontology should not drive research but should derive from it. He suggests that

critical realism based on empirical findings in the natural sciences does not translate into social sciences as adopting the philosophical standpoint prematurely closes the research questions that might be asked.

However, in their argument that critical realism is a sound basis for qualitative research based on inductive methods, Maxwell and Mittapalli (2007) counter many of these claims. They deny the accusation of positivism, stating that realists assume the world to be the way it is whilst acknowledging that it can be understood in a variety of ways (Lakoff 1987 cited in Maxwell & Mittapalli, 2007). Contrary to the dualist claim, through arguing that critical realism can be a framework for studying physical, psychological and sociological phenomena, it is clear that critical realists regard the mind and body as providing different types of information, not as belonging to different worlds. Despite his criticism, even Kemp (2005) approves of Pawson and Tilley's pragmatic use of critical realism to guide their research approach.

Realistic Evaluation is sometimes accused of privileging the evaluator's position rather than being truly participative (Patton, 1999; Gregory, 2000). Pawson and Tilley (1997) argue that, although both experts and practitioners should be involved in order to provide different information and insights, Realistic Evaluation acknowledges that the evaluator is the person ultimately guiding and abstracting from the data to produce the CMO configurations. This contrasts with Fourth Generation Evaluation (Guba & Lincoln, 1989) and other strongly constructivist approaches. Pawson and Tilley (1997) suggest this makes sense because stakeholders find it difficult to step back from their immediate involvement.

Another criticism levelled at Realistic Evaluation is that context is not problematised or operationalised (Davis, 2005) and the methodology cannot provide guidance if the complexity increases (Hansen, 2005). However, Pedersen and Rieper's (2008) evaluation of electricity supply and free markets in Denmark suggests that Realistic Evaluation is capable of guiding even complex evaluations. Hansen (2005) also suggests that CMO configurations are not robust because context sometimes collapses into mechanism, or mechanisms could be coded as

outcomes depending on the configuration. However, in their evaluation of a complex mental health intervention in primary care, Byng et al. (2005) found this lack of rigidity a useful way of considering CMOs. An outcome from one situation could lay the foundations for the context of the next and so on. The approach has also been accused of being too linear (Dickinson, 2006), an impression that figures of CMO representations may reinforce [see Figure 13]. These are necessarily simplified in order to convey configurations that can be cumulated. However, in outlining an approach for education research, Richter and Allert (2004) argue that there is no linear pattern in practice (context first, then mechanism then outcome, move onto the next). Rather there is mutuality, so that the outcome of one configuration can provide the mechanism for another. Instead of being linear and simplistic, these researchers found Realistic Evaluation could address complex issues that happen simultaneously or close together in time. This fits with the critical realist notion of generative rather than secessionist causality: things happen because of mechanisms in a certain context rather than because of a law stating that Y always follows X [see section 3.3.1]. This critique is revisited in the Discussion [section 7.2]

Because Realistic Evaluation suggests that mechanisms can be identified through the literature and from previous experience, and can then be verified in the data, [see section 3.3.3] there is a risk that researchers can merely confirm what they are looking for. However, as Pawson and Tilley illustrate [see Figure 8 below] these 'hypotheses' must also be tested and challenged in the data [see sections 5.1.1.1, 5.2.4, 5.3.4, 5.4.4 and 5.5.4]. The point of identifying CMOs from the data is to develop new hypotheses. New hypotheses developed from this study and presented as middle range theories will be presented in section 6.2.

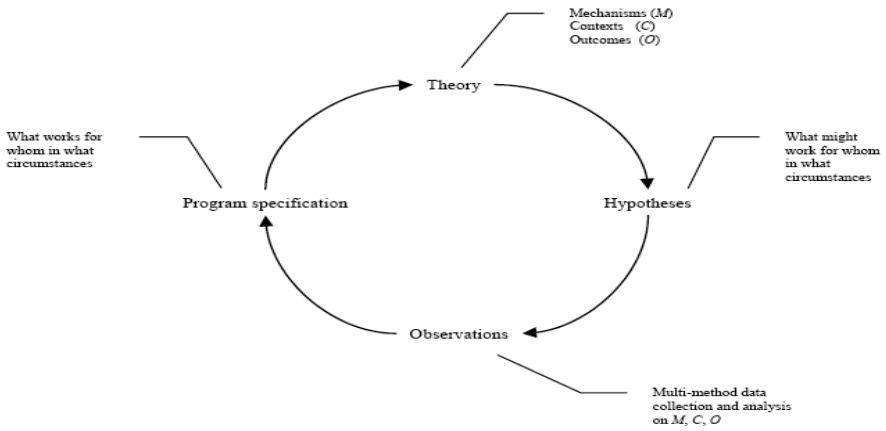



***Figure 8 Realistic Evaluation cycle***
***(adapted from Pawson & Tilley, 1997, p. 85)***

### *3.3.4. Use of Realistic Evaluation in healthcare and education research*

Realistic Evaluation attempts to look at the 'black box' of what works for whom and why. Increasingly, practical fields such as healthcare and education want to look into the 'black box', rather than just find out *if* interventions and programmes work (Kazi, 2003; McEvoy & Richards, 2003; Lipscomb, 2008). Realistic evaluation is being used in an increasing number of healthcare studies, ranging from (to name a few) the evaluation health promotion in schools (Pommier et al., 2010), protocol based care (Rycroft-Malone et al., 2010), nursing practice (Redfern et al., 2003), chronic heart disease programmes (Clark et al., 2007) to an expert patient programme in the NHS (Kennedy et al., 2005). As a methodology it has been in use for over 20 years but remains flexible with regard to the choice of methods used. Within the increasing number of published studies using Realistic Evaluation, it is clear that data analysis is not consistently linked to Realistic Evaluation's CMO framework. To illustrate this, three studies are critically analysed for their data analysis strategies within a Realistic Evaluation approach.

Firstly, Wilson and McCormack (2006) evaluated the implementation of an emancipatory practice development programme in a special care nursery. Their published paper makes a strong case for the use of a critical realist methodology to evaluate a critical social science based programme, but does not provide much detail about their research design or data analysis within a Realistic Evaluation framework. They state only that '*Data were analysed individually and then*

*compared*' (p. 53). Although explaining their processes was not the aim of their research report, no clues are provided to support understanding of how this process happened or how diverse data sets such as in-depth interviews, participant observation and survey data were analysed and integrated. While Wilson and McCormack thoroughly explain the importance of context, mechanism and outcomes in their introduction, their findings are not presented in this format. Consequently, it is difficult to identify what is considered a mechanism or an outcome.

Secondly, in his examination of pre-registration nursing students' perceptions of supernumary status, McGowan (2004) used 'sensitising concepts' and was clear about the questions he wanted to answer through student focus groups. However, instead of looking at contexts, mechanisms and outcomes from the outset (or identifying any of his questions as relating to mechanisms), he elected to analyse the focus group data thematically following Morse and Field (1995). Ten themes were identified and categorized into three groups. These were later re-categorised as context, mechanism and outcome:

> Considering the ten themes generated by this study the challenge became one of deciding which of the findings were mechanisms, which were contexts and which were outcomes. To facilitate this, design of the interview schedule used a realistic evaluation infrastructure where definition equalled context, operationalisation equalled mechanism and effect equalled outcome (McGowan, 2004, p. 26)

The implicit argument here is that the thematic analysis was a preliminary stage to applying the Realistic Evaluation framework. However, the way in which this analysis was undertaken gave the impression that Realistic Evaluation was belatedly bolted onto a traditional qualitative thematic analysis. By reducing the data to ten themes before attempting to identify C+M=O configurations the Realistic Evaluation framework was applied to a radically reduced version of the data corpus. This will have introduced a risk of overlooking some important facets of contexts, mechanisms, outcomes and their interplay, which were too subtle to form substantive themes in the thematic analysis.

Finally, Byng and colleagues' (2005) Realistic Evaluation of an intervention for long term mental health conditions in primary healthcare presents the process of

analysis much more clearly. The Realistic Evaluation reported in this paper complemented a traditional randomised control trial, after they found the explanatory power for their complex intervention was insufficient to understand the 'black box' of the intervention, beyond comparing outcomes of the intervention versus usual care. Through analysis, Byng and colleagues aimed to develop a middle-range theory of the context-mechanism-outcome relationships "*likely to be of importance*" (p. 73). To elucidate these relationships, the research team used a multi-stage process.

- Hypothesised context, mechanism and outcomes were identified, through literature review and discussion within the research team.
- Hypothesised CMO configurations were tested through interviews and specific contexts, mechanisms and outcomes were explored (as suggested in Pawson, 1996).
- Interview data was coded as context, mechanism or outcome.
- Mechanisms were coded as positive, negative or absent.
- The CMO configurations from the interview data were compared to those initially hypothesised.
- The next level of analysis compared CMOs and further abstracted the data into middle range theories that could be generalised as per Pawson and Tilley's (1997) notion of cumulation (Byng et al., 2005, p. 77).

Byng and colleagues also detail steps to increase the validity of their findings, such as looking specifically for positive and negative cases and going back to the original transcripts to ensure that contexts and mechanisms were truly contingent (p. 78).

Byng and colleagues' study provides a detailed and specific example of how Pawson and Tilley's approach could be operationalised in a healthcare research context. The current study had a different design [see section 3.5 below], however, elements from Byng et al., (2005) such as testing hypothesised CMOs and sensitising concepts [section 3.10.1] and the creation of middle range theories [see section 6.2] have influenced the analysis [section 4].

## 3.4. A multi-method study

As outlined below this study used multiple strategies in data collection and analysis in order to fulfil the three purposes of evaluation [descriptive, causal analysis and values inquiry, see section 3.1, p. 62]. The literature concerning multi-method research (commonly, if slightly confusingly, also termed 'mixed methods'

research) often focuses on combining quantitative and qualitative research strategies (Creswell, 1994; Gilbert, 2006; Greene, 2007; Frost, 2008). However, this multi-method (Bryman, 2007) Realistic Evaluation:

- Collected qualitative data from semi-structured interviews, during which the approach to questioning was guided by Appreciative Inquiry (Coghlan et al., 2003) [section 3.8.1.2]
- Extracted data from routinely completed assessment documents [Documentary analysis, section 3.8.2]
- Conducted an inductive analysis guided by Interpretive Description (Thorne et al., 1997; Thorne et al., 2004) [section 3.9.1] and the CMO framework of Realistic Evaluation (Pawson & Tilley, 1997) [section 3.3.1].

The literature from the mixed methods community focuses on methodologies divided across paradigms (conceptual models) of how the world is and is known (both ontology and epistemology). Realistic Evaluation could be seen to fit a *'new paradigm'* stance (Greene & Caracelli , 2003) that bridges traditional divides. This inclusive approach does not problematise the tension between methods but rather embraces multiple approaches. While setting out their case for Realistic Evaluation and offering a critique of other approaches, Pawson and Tilley state: "*we are whole-heartedly pluralists when it comes to choice of method*" (1997, p. 85) and later expand upon their support for multi-method evaluations (p. 154). For this study, which elicited multiple perspectives in pursuit of understanding how the ISP was used in practice, it made sense to use multiple research strategies (McEvoy & Richards, 2006).

Critics of mixed methods are concerned about the fidelity of analysis if different approaches are used (Miller & Fredericks, 2002), and different methods lead to conflicting findings (Rolfe, 2006a). However, in my reading of Realistic Evaluation, conflicting findings are not a drawback but can signal areas where mechanisms may not be triggered or indeed identify subgroups for whom something is *not* working [see section 3.3.3]. In this study, through challenging the data [see sections 5.1.1.1, 5.2.4, 5.3.4, 5.4.4 and 5.5.4], conflicts were unpacked not ignored, and the findings were richer for it.

## 3.5. Overview of study design

Figure 9 provides an overview of the study, showing when each aspect of data collection occurred.

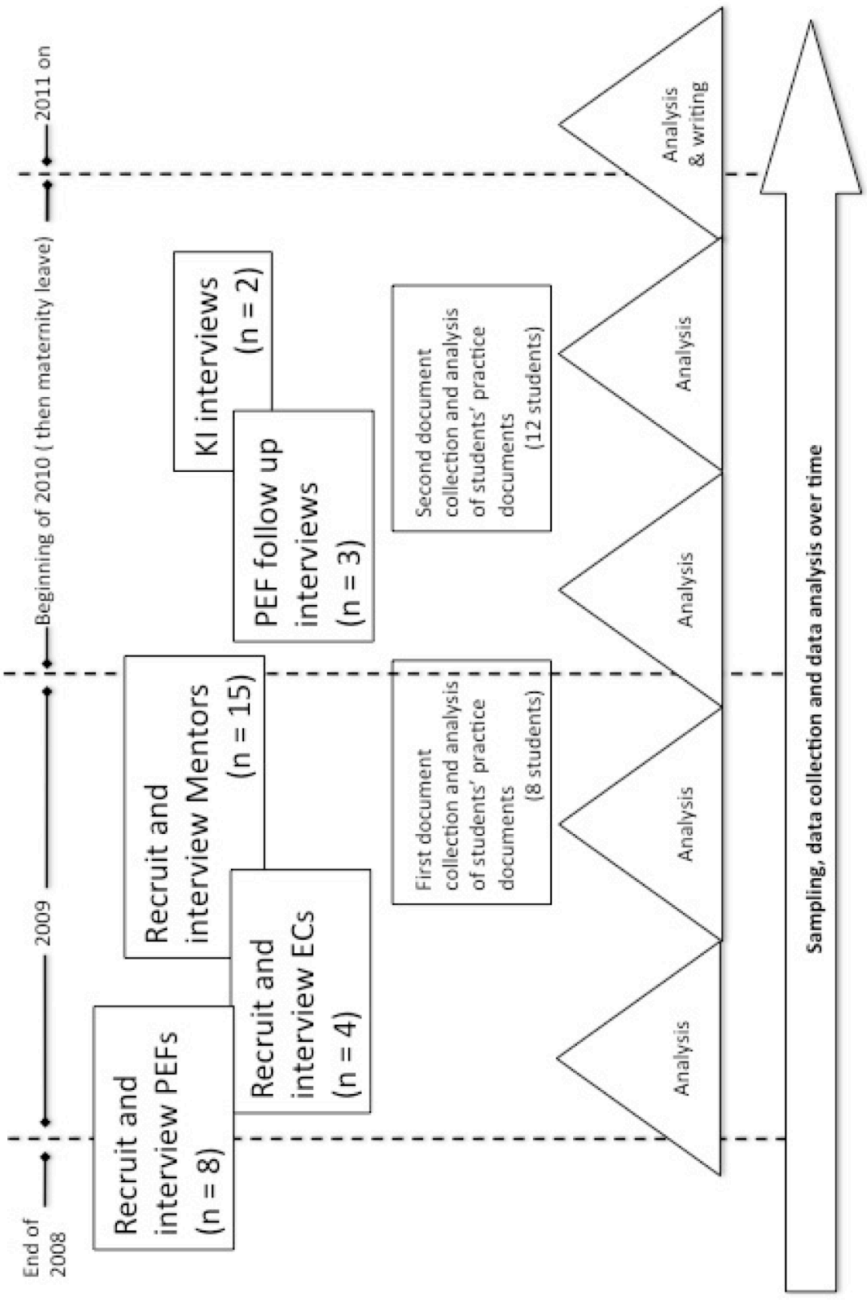



***Figure 9 Overview of the study***

The ISP is used by mentors who assess nursing students in their clinical setting [see section 2.4 and Appendix B]. In order to examine how the ISP was used in practice the study design centred on interviews with mentors to explore their

experiences of using the ISP [see section 3.8.1 and Table 3 p. 83]. Two important groups with roles supporting mentors, were consulted before mentor interviews began: Practice Education Facilitators (PEFs) [section 3.6.1] and Education Champions (ECs) [section 3.6.2]. Section 3.6 outlines the sampling strategy and provides brief details of recruitment to the study [see Table 2].

PEFs were approached first (late 2008) to gain an overarching view of assessment in practice across the HEI's multiple sites and with several healthcare provider organisations. We discussed their perceptions of how mentors responded to the ISP. Similarly, ECs were approached for an overarching perspective of assessment practices in the clinical areas to which they linked. The three groups (PEFs, ECs and mentors) were approached and interviewed in overlapping phases between late 2008 and early 2010 [see Figure 9]. This part of the data collection ended with three PEF follow-up interviews (early 2010) conducted via telephone [section 3.8.1.1]. The first three PEFs had been interviewed early into the adoption of the ISP and the study itself. The follow-up interviews were used to clarify some points raised in their earlier interviews, to check CMO configurations and in the case of PEF01 because she had offered to keep track of student issues more consciously with respect to the impact of the ISP.

In parallel, two phases of documentary analyses were undertaken [see section 3.8.2 and Figure 9]. After initial analysis of interview and documentary data, two Key Informants (KIs) were interviewed to check themes and test mechanisms emerging from the data [section 3.6.4].

## 3.6. Research participants

This study interviewed nurses, healthcare practitioners with responsibility for developing and supporting practice learning environments, nursing faculty and a nursing faculty administrator. In addition, documentary data in the form of practice assessment documents was collected from nursing students [see Table 2] At the outset purposive sampling of participants was planned on two dimensions: first, to include participants linked to each of the study HEI's three sites (A-C) [see section 1.3] and second, to include participants from each field of nursing (adult, children, learning disability and mental health) [see section 1.2.1]. The aim was to

recruit interview participants until data saturation had been reached (Coyne, 1997) [section 3.6.6].

The interviews formed four groups, beginning with eight Practice Education Facilitators (PEFs) [section 3.6.1], since their role in developing and supporting high quality practice placement learning provided an overview of practice assessment, the supply and development of mentors, and problems raised by mentors, students or the HEI. PEFs were also considered to be gatekeepers for the recruitment of mentors from their healthcare organisations [section 3.6.3]. PEFs were drawn from all three sites and were responsible for nursing placements from all fields of nursing.

| Group | Number of interviews/sets of documents | Fields | Sites (see Introduction 1.3) |
|---|---|---|---|
| Practice Education Facilitators (PEF) | 8 interviews (7 transcribed, one recreated after recording failure)<br>3 follow-up interviews (PEFs 01-03) | All support a variety of fields. 1 with emphasis on Child, 3 with emphasis on Mental Health | Sites A, B and C and cover wide geographical placements area (all types of placements) |
| Education Champions (EC) | 4 (all transcribed) | All support a variety of fields, majority of areas in Adult field | Sites A & B (acute care, specialist and district hospitals) |
| Mentors (M) | 15 (14 transcribed, one recreated after recording failure) | 10 Adult<br>4 Child<br>1 Learning Disability | Linked to site A only (mostly one acute care trust and some independent sector) |
| Documentary Analysis (DA) | 20 sets (16 complete) | 16 Adult<br>3 Mental Health<br>1 Learning Disability | 11 site A<br>3 site B<br>6 site C |
| Key informants (KI) | 2 (both transcribed) | Faculty KI: Adult field<br>Administrative KI: all fields | Sites A and B |

***Table 2 Research participants and data collected***

It took some time to recruit mentors to participate in the study; meanwhile interviews were conducted with four Education Champions (ECs) [section 3.6.2]. ECs are senior nursing faculty who manage the relationships the HEI and clinical placements over a wide geographical area. Thus they have an overview of the curriculum, assessment practices and mentorship. EC participants were recruited from sites A and B. They had oversight of placements from all fields of nursing.

PEFs and ECs were approached through emails sent by a third party (either via the Strategic Health Authority[6] (SHA) or at the HEI).

Mentor recruitment proved difficult [section 3.6.3] but 15 mentors were recruited over a 10-month period. These were all linked to Site A and worked within the Adult, Child and Learning disability fields.

Towards the end of the data collection period, when a first analysis of the earlier interview and documentary data was completed, two Key informants (KIs) were interviewed to clarify some aspects of the data and test the emerging analysis [section 3.6.4].

For the documentary analysis [section 3.8.2], two cohorts of students on all three academic sites [see Introduction, section 1.3] were invited to participate (approximately 300 students). Students near the end of their second year (the end of their eighth module) were approached because they had been assessed on both the first year and second/third year criteria of the ISP [see section 2.4 and Appendix A]. Two rounds of document collection were separated by six months [Figure 9]. Table 2 shows that a small number of students from each study site submitted their practice assessment documents. These documents spanned placements in Adult, Child and Learning Disability nursing fields.

The majority of participants in all categories were women; for example, only three men were interviewed. Due to small numbers of men working in PEF, EC and KI roles, all participants are referred to as female in order to strengthen the anonymity of male participants' words [see section 4.1.1 for more detail].

### *3.6.1. Practice Education Facilitators*

To access experiences of using the ISP to assess students' interpersonal skills, the study design included interviewing two groups of participants who had access to many mentor-student interactions.

[6] During the data collection period Strategic Health Authorities (SHAs) commissioned HEI providers to train students in each health care profession.

The title Practice Education Facilitator has various meanings depending on the context of use (Mallik & Aylott, 2005; Dickson et al., 2006; Lambert & Glacken, 2006; Jowett & McMullan, 2007; Hyatt et al., 2008). In this study, a PEF was defined as a healthcare professional (at the time of data collection the majority were nurses) whose role is to support those professionals who support student learning. Importantly, the PEF was seen as belonging neither to practice (the Trusts) nor to the HEI as they were hired by the SHA. In the study area, the PEF role had evolved from a specific role in site C, providing one-to-one support for mentors [see Introduction, section 1.3.1.2], to a broader role supporting mentors across health professions and with greater focus on strategic support for clinical education and placement capacity building. Some of the PEFs recruited to the study had been in post for several years and had adapted to these role changes, others were newly recruited and only ever worked as PEFs with the broader capacity building and multi-professional support roles.

PEFs were recruited through an email sent via their manager. I provided more information by making a short presentation and answering questions at a monthly PEF meeting. PEFs then got in touch through email to arrange face-to-face interviews lasting up to one hour. Eight PEFs were recruited to the study, the first three of whom gave briefer follow-up telephone interviews between 12 and 16 months after their initial interviews [see Figure 9]. The follow-up interviews were used to revisit the PEFs earlier views and to explore the emergent analysis, including provisional CMOs.

Data from seven PEF interviews (PEFs 01, 02, 03, 05, 06, 07 and 08) were analysed because it became clear only after the interview had begun, that PEF04 did not meet the inclusion criteria of the study as her catchment area did not include students using the ISP. Her views on professionalism and assessment of interpersonal skills were interesting but did not ultimately form part of the data set. PEF06 was new in post and had a non-nursing background. While her interview forms part of the data set that was analysed, she is not quoted in the thesis as her experience with the ISP, supporting mentors and with assessing nursing students was superficial. The examples PEF06 provided were limited to practical issues around using the document and logistics of student assessment.

PEFs had variable experience ranging from one to 12 years in post. Except for PEF04 and PEF06 all were nurses by profession.

### *3.6.2. Education Champions*

The role of the Education Champion came into being in the study HEI in January 2009. As with many other institutions, the study HEI struggled to find the best way to support pre-registration students and mentors in the clinical setting (Chapple & Aston, 2004; Sharples et al., 2007; Hyatt et al., 2008). ECs were nursing faculty who lead faculty teams assigned to large clinical areas (e.g. a hospital or community trust). The EC was named as the main contact point between that area and the HEI. She provided regular and accessible support to mentors.

EC participants were recruited through an email from an Associate Dean at the HEI. ECs from all sites were invited to participate, but all those that responded were former colleagues from sites A and B. It is possible that these participants were more aware of the study than their counterparts in site C and were thus motivated to participate [see section 3.7 on research ethics]. Informally, and through discussions and observations with nursing faculty from site C, the ISP had been well received. Furthermore, nursing faculty from site C formed 60% of the sample responding to the web-based survey reported in section 2.4.1. As a group, nursing faculty were supportive of the ISP with over 70% agreeing or strongly agreeing to all statements about the ISP [see Table 1, p. 57]. The participating ECs had a minimum of five years experience at the HEI and minimum of ten years in practice as nurses, all worked primarily in the Adult field but supported students and mentors in a range of fields.

### *3.6.3. Mentors*

The current study sought to evaluate the mentors' use of the ISP and mentors were envisaged as the main group of participants. Mentors typically have poor response rates for research (Parker, 2003; Jinks, 2007) therefore the original design envisaged the use of a more personal snowball recruitment strategy (Goodman, 1961; Noy, 2007) by asking the participating PEFs and ECs to invite mentors to participate in the study. It was hoped that PEFs and ECs would directly hand mentors an information pack. The hypothesis was that this personal contact

would increase response rates. Unfortunately, this was not a successful recruiting strategy despite over 60 packs being distributed by PEFs who reported having interest from mentors. None of these contacted either the study email address or study phone. One postal return was received; this contained no contact information, only the signed consent form. Thus after reviewing the strategy, mentors were accessed through a direct email to Hospital Trust mentor email lists from a third party [a neutral hospital mentor coordinator]. This yielded 18 responses (all from one Trust) that resulted in 15 interviews[7] [see Table 3 p. 83]. Mentors 05 and 06 were interviewed by telephone [noted with a t on Table 3], due to logistical problems in organising a face-to-face interview. These were shorter than the face-to-face interviews [see section 3.8.1.1 on telephone interviewing]. All mentor interviews contributed to the analysis reported in subsequent chapters, but they are not equally quoted in the thesis [see sections 4.1.1 and 8.1.5]. Characteristics of the mentors interviewed can be found in Table 3. The majority of mentor participants supported students in the sessionally-based placements [described in section 1.3.1.2] over a period of weeks or months.

However, two mentor participants supported students differently. Mentor 02 was based in an outpatient area that had students for a short period, and was not familiar with the ISP. Her interview was a response to seeing the ISP and her experiences of trying to assess interpersonal skills in a short space of time. As a practice development nurse, M03 had a role more similar to PEFs supporting mentors who were supporting pre-registration nursing students. However, M03 supported and assessed registered nurses in continuing education and had used the ISP for qualified these students.

[7] Three mentors who responded either provided incomplete contact information or were unavailable to interivew.

| Number | *Clinical area* | *Role* | *Mentor status* | *Experience mentoring* |
|---|---|---|---|---|
| **M01** UK trained | Adult medicine, in-patient | Ward Manager/ Senior Sister | Mentorship course university | Many years Confident (self described) 1st and 3rd year students |
| **M02** Trained abroad | Adult medicine, out-patient area | Home support for service, senior nurse | Mentorship course university | Infrequent students, not at placement for long Hadn't seen ISP before… interview a response to seeing it first time |
| **M03** UK trained | Adult surgery, acute, many in-patient areas | Practice development nurse | 2 mentorship courses and mentorship pathway | More on new nurses/preceptorship, previous experience but in another trust – overview |
| **M04** UK trained | Adult medicine, in-patient | Junior sister | Mentorship course recent, NVQ assessor's course | Mentorship experience, interest in educating students, previous NVQ. 1st and 3rd year students |
| **M05** UK trained | Adult medicine, in-patient | Junior sister | 8 day mentor course in 2007 sign-off mentor | 2006 qualified, began to mentor that year. 1st,2nd and 3rd year students |
| **M06 (** Trained abroad | Child surgery, in-patient | Staff nurse | Qualified mentor 2008, sign-off mentor | Student coordinator, 1st,2nd and 3rd year students |
| **M07 (** UK trained | Learning Disability, community | Staff nurse | On the mentor course at time of interview | Limited experience, newly qualified, in first year. 1st year students |
| **M08** Trained abroad | Adult surgery, in-patient | Junior sister | Mentor course in 2008 | Many students, return to practice nurses, 1st,2nd and 3rd year students |
| **M09** UK trained | Child, critical care area | Staff nurse | Mentorship course 2007 | Short placements, from 1 day to 3-4 weeks other types of students too 2nd and 3rd year students |
| **M10** UK trained | Child surgery, in-patient | Staff nurse | Mentorship finished April 08 | Supported students prior 04/08 but didn't sign docs, students 4-8 weeks 2nd and 3rd year students |
| **M11** UK trained | Adult surgery, in-patient | Staff nurse | Mentorship course 2007 | 3 years experience, 1st and 3rd year students |
| **M12** UK trained | Child medicine, In-patient | Staff nurse | Course 2007 Doing masters in Healthcare education | Student link 1st,2nd and 3rd year students, base placement |
| **M13** UK trained | Adult medicine, in-patient | Junior sister | Mentor course 2008 | Students in 1st year |
| **M14** UK trained | Adult, critical care area | Junior sister | Mentor course pre 2006 | Student link Ward only had students 7 months prior to interview, 2nd year students |
| **M15** UK trained | Adult, critical care area | Practice development nurse | Mentor course pre 2006 | Student link, 2nd year students |

***Table 3 Mentor participants***

### *3.6.4. Key informants*

In this study Key Informants were selected in order to check themes and CMOs emerging from the data. According to Gilchrist and Williams (1999),

> "Key informants are individuals who possess special knowledge, status or communication skills who are willing to share their knowledge and skills with the researcher and who have access to perspectives or observations denied the researcher through other means" (Gilchrest & Williams, 1999, p. 73).

The KIs in this study were specifically approached for their particular knowledge and experience. Both of those approached agreed to participate. KI1 was a HEI nursing faculty member in the Adult field who did not have an EC role but who was involved in mentorship preparation and teaching and KI2 had an administrative support role for students and was very familiar with the student experience of assessment for students in all fields and the HEI regulations. These interviews, conducted after the majority of data collection and preliminary analysis addressed some of the tentatively identified CMO configurations as well as seeking the KIs' opinions and experiences of the practice assessment strategy and the ISP.

### *3.6.5. Students*

Students at all three sites and all fields of nursing were approached to participate in the documentary analysis [see section 3.8.2]. Students at the end of their second year were recruited through a short (five minute) presentation at a lecture in the last weeks of Module 8 (the end of year two of the programme) which was delivered either by nursing faculty with no assessment responsibilities for the cohort at sites A and C or by me at site B. Students were invited to submit all of their practice documents (covering eight modules) the following day, for return within a week. The times chosen did not interfere with planned document hand-in dates.

Data collection was confidential in that students put the documents and a signed consent form into an envelope before entering the lecture room. After photocopying the relevant pages all identifying names were blacked out and the student document assigned a number. The original documents were returned via the HEI's hand-in centres, ensuring that personal tutors had no knowledge of their participation. Students were also guaranteed that no action would be taken if

irregularities were found in the assessment documents. However, due to the nature of the nursing profession and the requirement for good character (NMC, 2007b), students were informed that fraud would be reported to the Director of Studies.

The first cohort to participate in this study (September 2007) were also the first cohort of students to start in the new programme, thus mentors had no previous exposure to the ISP. Twelve students from the Adult field responded to the first collection. The second cohort (March 2008) had started six months later and provided documents used by assessors who had perhaps had more time to become familiar with the practice assessment documents. The second cohort also provided a more diverse sample with a four Adult, three Mental Health and one Learning Disability field students submitting documents. Despite being approached in both collections, no Child field students submitted documents for analysis. In total 20 students submitted documents (with 16 complete sets) over two collections [see Table 2]. Within these documents 100 mentors made over 250 formative and summative uses of the ISP.

### *3.6.6. Sample size and data saturation*

Sample size in qualitative research is often described in vague terms (Guest et al., 2006), frequently justified by reaching 'saturation' without clarifying what it means or how it was reached (O'Reilly & Parker, 2012). Bowen (2008) distinguishes between data and theoretical saturation suggesting researchers should identify which they have achieved. Data saturation means recruiting new participants (or gathering new data) until data replication or redundancy indicates the data set is complete. As Guest and colleagues (2006, p. 65) defined it "*the point in data collection and analysis when new information produces little or no change to the codebook*". Theoretical saturation, which comes from grounded theory, is when no new insights or themes are identified (Bowen, 2008). Noting that the term has been adapted generically in qualitative research O'Reilly and Parker (2012) suggest that unless the type of saturation and way of achieving it is articulated in published research the term risks becoming meaningless. The current study aimed to achieve data saturation and participants were interviewed until there was redundancy in the data set and no new codes were developed in the initial analysis

[see section 4.2.1]. In subsequent cycles of analysis further themes and codes were developed from the existing data set [section 4.2.3].

In qualitative research saturation forms the basis for sample size. As with much qualitative research the sample size was not predicted at the outset of this study (Guest et al., 2006) but estimated using Morse's guidelines (Morse & Field, 1995; Morse, 2000) suggesting that using semi-structured interviews, around 30 participants would be needed. Morse (2000) notes that qualitative research sample sizes depend on a variety of factors such as scope of the topic and heterogeneity of the sample. In their investigation into the number of interviews required to achieve data saturation in a focused study with a homogenous sample, Guest and colleagues (2006) noted that nearly all codes had been identified and refined in the first 12 interviews: the further 48 interviews in their study contributed to the depth of the data but added very little on a coding or thematic level. The current study asked a focused research question and interviewed a sample with the relatively homogeneous background of nursing education. Additionally, PEFs and ECs were particularly interviewed for their 'shadowed data' or reporting of others' experiences (Morse, 2000) thus increasing the range of data collected. O'Reilly and Parker (2012) suggest that researchers who collect data with a defined research agenda, such as the 'sensitising concepts' [discussed in section 3.10.1] and search for CMOs [section 3.3.1] in this study, require a smaller sample size as data collection is more targeted than those with broad and unfocused enquiries. The interviews were semi-structured [see Appendix D] accessing the participants' thoughts, experiences and opinions but within parameters decided by the research agenda.

Sample size in the documentary analysis [section 3.8.2] depended on student response. In the current study a second document collection was undertaken as the first was insufficient for data saturation. The second set of documents provided more depth to the documentary analysis which could then be used to test CMOs developed from the interview data.

## 3.7. Research ethics

Research, especially qualitative research involving interviews with participants, is not a value neutral undertaking (Hewitt, 2007). The confidentiality of information and anonymity of participation was guaranteed to all participants (Sikes, 2006), with the exception of reporting any fraud detected in practice documents [section 3.6.5]. The researcher-researched relationship must be considered and ethical considerations are integral to good research design. Sikes (2006) draws attention to the interface of the personal and the professional in researcher decision-making, which affects research from the question through to analysis and presentation of findings. She advocates reflexivity of the researcher (avoiding narcissism) and respect for participants at all stages. As a novice researcher investigating what was part of my professional practice at the beginning of the study [see Figure 10 representing my personal timeline during the study period], issues of research on vulnerable groups (in this case students [section 3.7.1] and colleagues [section 3.10]) had to be considered (McGinn & Bosacki, 2004). Recruitment strategies and relationships with current and former colleagues had to be considered. For instance, though all EC respondents had been former colleagues from site A or B [section 3.6.2,], no attempts to recruit outside of the email sent by a third party at the HEI were made. The implications for the study are unclear and are further discussed in the Limitations [section 8.1.2].

In addition to respect for confidentiality and attention to power balances within the researcher-participant relationship, the quality of research was also an ethical issue. Poorly designed research with a lack of rigorous analysis is also an abuse of participants' time and engagement and the research process (Koch, 1994). In this study, I aimed to complete a well-designed and rigorous study.

Through seeking approval from both the HEI faculty and NHS Research Ethics Committees, I was forced to consider how to recruit and interview colleagues and ask students to provide their practice documents without placing them under undue pressure. These bodies required justification the design, interview schedule and plans for data analysis and eventually publication. These processes contributed to a more robust and solid research design and undertaking. The following section addresses ethical issues particular to students who form a

vulnerable group.

### *3.7.1. Ethical issues regarding students in research*

As a senior nursing faculty at the study university, there was initially a potential power imbalance with students. However, by the time students' practice placement assessment documents were collected I was in a clinical role [see Figure 10, p. 94]. Despite not having overt authority over students during the documentary analysis, processes were put in place to minimise a potential sense of obligation to participate. The process of document collection required collaboration of former colleagues (nursing faculty) working at the HEI in order to provide information about the study and recruit students from the three major sites (A, B and C). Only nursing faculty who were in no way responsible for grading the participating student cohorts were involved in recruiting students and collecting documents (Ferguson et al., 2006). Students were able participate (or not) without the knowledge of their personal tutors, and their practice documents were returned swiftly, within a week [see section 3.8.2]. To ensure ethical standards were met, permission was sought from the HEI Faculty Research Ethics Panel.

## 3.8. Data collection

As discussed in section 3.4, Realistic Evaluation, within the critical realist paradigm, supports the use of multiple methods. Both documentary analysis of practice and interviews with the major stakeholders in the assessment process were conducted; PEFs, ECs and mentors were interviewed face-to-face or by telephone. Data analysis from the interviews began during PEF interviewing [see Figure 9] and early interview data informed questions in later interviews following qualitative collection and analysis methods.

### *3.8.1. Interviewing*

Interviewing in qualitative research is as much an art as a science (Coar & Sim, 2006) and is a skill that was continuously developed over the course of the study. Initial interviews contained classic novice errors as I over-talked, over-interpreted and asked leading questions reflecting some of the sensitising concepts (Holloway

& Fulbrook, 2001)[section 3.10.1, limitations further addressed in section 8.1], however, my technique improved with guidance from my supervisors. Prior to undertaking the first PEF interview there was opportunity to practice with three mock interviews, two with student volunteers from City University and one with a supervisor.

Interviews were semi-structured conducted with question frames for each category of participant and prompts [see Appendix D for questions and prompts]. Participants were initially asked to explain why they had agreed to be interviewed in order to set the tone of the interview and make sure their perspectives led the conversation. At the end of the interview, participants were asked if there were any issues that they wished to raise. Interviews within each group of participants began with a focus on identifying similarities and differences in context, uncovering perceived outcomes of the ISP and testing or checking 'sensitising concepts' [section 3.10.1]. Later interviews included checking mechanisms identified in early interview data (Pawson, 1996).

#### 3.8.1.1. Telephone interviews

Two mentor interviews (M06 and M07) and the PEF follow-up interviews (PEFs 01, 02 and 03) were conducted by telephone due to scheduling issues. Interviews by telephone were conducted in the same way as face-to-face interviews but were shorter. The two mentor telephone interviews yielded 12 pages of transcript versus an average of 17 pages for face-to-face interviews. A review of the transcripts shows that less time was spent establishing the interaction and the interview was more focused with fewer digressions by the participants. However, the substance of the interviews was comparable. The follow-up PEF interviews were also significantly shorter (around half as many transcript pages), however the follow-up interviews were more focused and built on statements made in the first interview rather than following the semi-structured interview guide of the initial interview [see Appendix D]. Additionally, building on the rapport developed through the face-to-face interview meant less time was required to establish a connection in the follow-up interviews (Irvine, 2010).

The literature on telephone versus face-to-face interviewing in qualitative research

has not clearly determined the differences between them (Irvine, 2010). It has long been noted that non-verbal cues and interpersonal interactions are missing in telephone interviews (Miller, 1995). However, Sturges and Hanrahan's (2004) study found that respondents (50% face-to-face, 50% telephone) provided similar responses regardless of interview mode. In her reflective and research-based account comparing face-to-face and telephone interviews, Irvine (2010) reported similar findings. She maintains the main research questions were addressed despite noting that telephone interviews were shorter and opportunities "[…] *to capture that valuable nugget of information that is often offered as a postscript once the recorder has been turned of* […]" (Irvine, 2010, p. 5) were limited. Ideally, all mentor interviews would have been carried out in person, however, it was decided that phone interviews were preferable to losing the participation of the respondent.

#### 3.8.1.2. Appreciative Inquiry

The semi-structured interview guides [see Appendix D] incorporated an element of Appreciative Inquiry (Ludema, 2001; Coghlan et al., 2003; Preskill & Coghlan, 2003; Marks-Maran & Fergy, 2007). The relatively recent approach comes from the organisational development literature and focuses on what is currently working well and asking how things might change for the better in the future (Carter, 2006; Cooperrider & Srivasta 1987 cited in Grant & Humphries, 2006). There are potential risks, such as overstating the positive or inadvertently asking respondents to comment on an ideal rather than their reality (Grant & Humphries, 2006), however, Appreciative Inquiry is an attempt to correct the tendency in evaluation to look at deficits and failures, by asking people to also think about what has been effective, and to articulate what ideal they might strive to achieve (Carter, 2006). In this study, Appreciative Inquiry informed the tone and focus of the interviews by asking for examples of good practice, what had been useful about the ISP or ways in which the tool not only gave critical but positive feedback to students.

### *3.8.2. Documentary analysis*

Documentary analyses of practice documents were conducted in order to determine:

1) Which items tended to be selected on the Interpersonal Skills Profile (ISP),
2) Timing of assessments
3) Student and mentor comments about performance and achievement in the practice setting.

The data collection was timed so as to avoid conflict with hand in times [see more detail in section 3.6.5]. All comments made by mentors and students in the ISP comment boxes were transcribed and analysed using the AtlasTi qualitative data analysis software. All items selected on the ISP were entered into an Excel spreadsheet [see Appendix E]. The response rates were poor [less than 7% with 20 students out of a potential pool of over 300] with documents from 20 students (16 complete sets) [see Table 2, p. 78]. Nonetheless, this small response provided comments from 100 different mentors and over 250 uses of the ISP. As with any research that relies on volunteers, those that respond may not represent the 'norm' or average (Lonnqvist et al., 2007) [see section 8.1.2]. The students that supplied documents in this study did very well overall [see Table 8, p. 126]. Only 34 choices selected items below 14[8] [out of a total 1,142 items scored (5 items are selected for each formative and summative). One student submitted a document with items that were a fail in all years (lower than eight) and one other student submitted a document with borderline items. It is likely that the participating students' achievement was higher than average, although this cannot be confirmed through this study [see also section 3.7.1].

## 3.9. Data analysis

The process of analysing interviews in qualitative research varies depending on the aim and methodology of the research. As this study was a Realistic Evaluation, the analysis was focused around identifying CMO configurations (Pawson & Tilley, 1997; Kazi, 2003) [see section 3.3.1]. A basic inductive qualitative analysis process was followed (Elo & Kyngas, 2008) with Interpretive Description (Thorne et al., 1997) [section 3.9.1], which recognises the use of sensitising concepts [see also section 3.10.1], as the analytic framework.

Starting with the interview data, using the AtlasTi qualitative data analysis

[8] Items 13 to 8 borderline items, i.e. are pass in first year and fail in the second two years [see section 2.4 p.54] or fails [see Appendix A p. 265 for the complete tool].

software (version 6, Scientific Software Development 2007), codes were identified and refined over repeated readings (Burnard, 1991) [see Data Analysis, section 4.2.2]. After code groups had been defined from the interview data, the comments from the documents analysis [see section 3.8.2] were also analysed using AtlasTi. A separate analysis was done of the item numbers selected on the ISP using Microsoft Excel [see Appendix E]. Grouping the codes together, CMO configurations were then developed and refined. Developing the CMOs included an explicit search within the data for negative cases. The data from the documentary analysis was specifically used to challenge the CMOs [see sections 5.2.4, 5.3.4, 5.4.4 and 5.5.4].

### *3.9.1. Interpretive Description*

Interpretive Description is a conceptual framework (Thorne et al., 1997), grounded in nursing science that can provide a coherent approach to using qualitative methods and testing hypotheses. This approach fits with Realistic Evaluation as it acknowledges that researchers come to a question with ideas informed from their practice or experience, which is usually what stimulated them to conduct research in the area. Interpretive Description embraces this existing knowledge base and suggests that it can be used to guide analysis of the research (Thorne et al., 2004). Furthermore, it suggests that grey (professional, non-academic) literature can provide a means for testing concepts and insights emerging during data analysis.

Interpretive Description is a 'non-categorical' approach that has been used in a variety of health related studies ranging from communication in cancer care (McPherson & Thorne, 2006) to battered women (Irwin et al., 2002) but also in health and nursing education (Gillespie, 2002; Van Hofwegen et al., 2005; Wellard et al., 2007). These studies relate study data to pre-existing knowledge, going beyond the lived experiences of their informants by interpreting and abstracting the data to form theoretical contributions (Caelli et al., 2003).

Caelli and colleagues (2003) suggest that this approach raises questions about qualitative rigour, as it seems to lift qualitative methods out of their historical and philosophical context. Countering such suggestions, Thorne (2000) suggests that Interpretive Description deliberately makes use of Morse's (1994) four-stage

generic model of qualitative analysis used by many qualitative researchers regardless of stated methodological approach:

> *"comprehending* the phenomenon under study,
>
> *synthesising* a portrait of the phenomenon including relations and linkages,
>
> *theorising* about how and why these relations appear as they do
>
> *recontextualising*, or putting the new knowledge about phenomena and relations back into the context of how others have articulated the evolving knowledge." (Thorne, 2000, p. 70)

In this study, these concerns were also addressed through identifying Realistic Evaluation as a clear methodological underpinning [see section 3.3] and an attempt to reflexively and openly articulate main influences and thinking [see section 3.10].

In line with Interpretive Description, through being immersed in the practice assessment literature prior to data collection some tentative 'hypotheses' (CMO configurations) or 'sensitising concepts' (Blumer, 1954; Bowen, 2006) were developed [section 3.10.1]. The primary research question [section 2.6] arose from previous findings and gaps in the literature and the secondary questions were influenced by Realistic Evaluation. The sensitising concepts and research questions informed the semi-structured interview frame [Appendix D] as well as providing a starting point for mechanisms.

## 3.10. Reflexivity and insider research

While not everyone agrees, I believe the researcher is one of the tools of research. The researcher influences the choice of research questions, the approach, the interview and the analysis (Morse & Field, 1995; Morgan, 2007). To turn this subjectivity from a liability into a strength, reflexivity and awareness of self are essential (Arber, 2006; Brannick & Coghlan, 2007).

As my professional role changed over the course of this study [see Figure 10], the definition of 'insider' changed. Initially I was an 'insider' to the academic setting and ECs were my colleagues. However, with a move to the practice setting I became an 'insider' to practice and therefore practice assessment. This raised both ethical and methodological issues, questions of access and coercion and quality of interpretation (Groundwater-Smith & Mockler, 2007) [discussed in section 3.7].

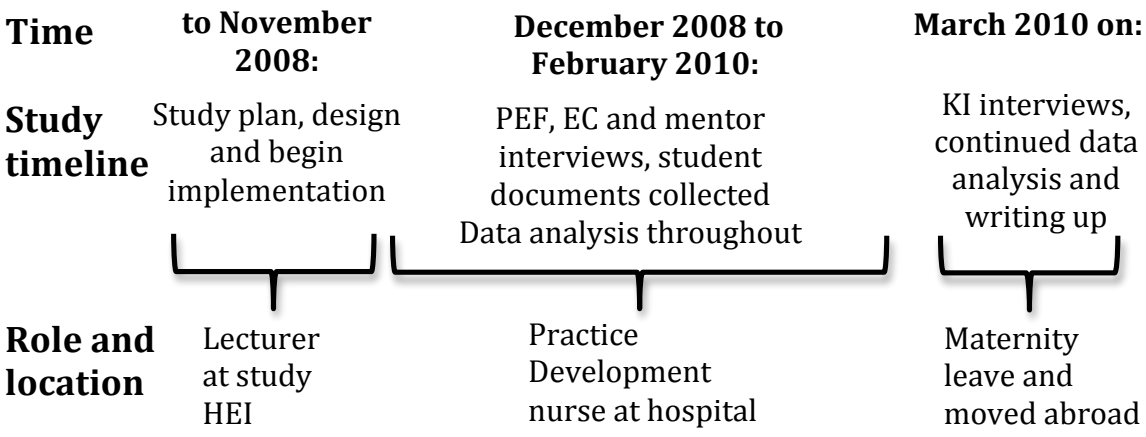



***Figure 10 Timeline of personal changes throughout study period***

Brannick and Coghlan (2007) mount a strong defence of insider research highlighting that tacit knowledge–as long as it is articulated—can add richness to the study design and analysis processes. They also point out that any insider is only an insider to a part of the setting and experience. Access to some participants might have been easier, [in this study most of the ECs were former close colleagues] but access to others was a challenge [mentors and students were still difficult to recruit]. Insider researchers must also overcome preconceptions and even friendships to move into the researcher and interviewing role (Chew-Graham et al., 2002). At no point in this study did I have a powerful role over any of the participants being interviewed, I no longer worked in academia and for clinical mentors, I had no sway over line managers or involvement in their clinical area. None of the mentors were recruited from my particular place of work within the Trust. Although one can never be certain how participants feel, this may have minimised the feeling that interviews were like a test (Coar & Sim, 2006) or that there would be negative consequences from providing information.

In addition to the drawbacks of insider research, there are also advantages. Insiders, particularly doctoral students, often generate a question that derives from their own experiences (Anderson, 2002) which may make it more relevant to practice and even if action research methods are not used can provide a 'grass-roots' approach to research. Anderson and Herr (1999) point out that subjects like education and healthcare, made up of academic and practice components, are particularly suited to practitioner research. A practitioner researcher is often

driven by a desire to make an impact on the local setting as well as on more generalisable goals. From a methodological standpoint, Caelli et al. (2003) note that inductive qualitative methods are appropriate for practitioner researchers who cannot approach the setting from an outsider's point of view. However, as Shaw (2005) notes, this research is often undertaken alone, outside larger programmes of research.

The challenge to the researcher is maintaining clarity of boundaries between roles with colleagues (Arber, 2006). In this study, I moved away from the university setting and into the practice setting, and took on multiple insider/outsider roles. Throughout I was able to maintain the sense of being a researcher, not a practitioner, as the roles were distinct from the groups being researched [see also Reflections 8.2].

### *3.10.1. Sensitising concepts*

Following Byng et al.'s (2005) [section 3.3.4] use of hypothesised CMOs, before data analysis began notional mechanisms and contextual factors were developed through both familiarity with the setting [see Introduction 1.3 and section 3.10 above] and the Literature Review [chapter 2]. These became sensitising concepts [section 3.3.1], i.e. ideas that were a point of departure in "*directing rather than determining*" (Downward et al., 2002, p. 490) a way in which to approach and interrogate the data (Bowen, 2006).

The sensitising concepts related to the context of practice assessment were largely negative, focusing on what did *not* happen in student practice assessment prior to the introduction of the ISP as well as impediments to practice assessment. Despite changes in nursing education in the UK since the study began [see section 1.2.1], the broad context of mentor assessment of student nurses' practice remained relatively unchanged in that nurses who acted as mentors still faced major pressures of time and resources in the educational role, which remained additional to their usual work.

Theorised Contexts[9]:

- As mentors are busy with little time to assess in practice and little assessment preparation [section 2.3.1.2]:
    - Mentors norm reference [section 2.3.1.2]
    - Interpersonal skills/professionalism implicitly assessed [section 2.3.2.2]
    - The ISP assesses 'authentic' situations, the student in practice [section 2.3.3]
    - The NMC SLAiP standards developed and published to support learning in practice (NMC, 2006; 2008b) [section 1.2.1.3]

The theorised mechanisms focussed on a lack of assessment of interpersonal skills, untimely formative feedback and students being given the benefit of the doubt [see section 3.3.1]. Some of the hypothesised mechanisms were around ways the ISP might address these deficits.

- Theorised Mechanisms[10]
    - ISP provides explicit/formal way to assess interpersonal skills/professionalism
    - Provides criteria to reference against
        - Mentors and students aware of criteria
    - Formative feedback can improve performance [section 2.3.2, p. 28]
    - The ISP is easy to use, which will impact on assessment in some way

## 3.11. Methodology conclusion

The methodological approach of this study, Realistic Evaluation, informed the study design, choice of methods and data analysis. From the Literature Review and personal experience certain concepts to be interrogated were identified within the data [see section 3.10.1]. Four main groups of participants, PEFs, ECs, mentors and KIs were approached for interviews, and documents including comments by mentors and students were collected for analysis. The following chapter [Data Analysis] presents the initial approach to data analysis and the resultant first level findings. Chapter 5 will present the main findings of this study, and chapter 6 the result of further cycles of analysis, testing and abstraction.

[9] Context "…*features of the conditions in which programmes are introduced that are relevant to the operation the programme mechanisms.*" (Pawson & Tilley, 2004, p. 6).
[10] Mechanisms refer to the processes that are identified as having been triggered by the intervention in the context, which lead to certain outcomes (Pawson & Tilley, 1997)

# 4. Data Analysis

## 4.1. Data Analysis overview

The core of qualitative research is, arguably, data analysis. Without analysis and abstraction, interviews, documents and observations remain descriptive, located in the particular and the contextual and threatening to render qualitative findings local, bounded and unable to be generalised (Graneheim & Lundman, 2004) [see Methodology, 3.3.3]. Through analysis, however, qualitative data transcends the particular. Uncovering the links and themes in data raises the possibility of transferability of the findings of a study. This chapter explores how the identification of mechanisms and outcomes in Realistic Evaluation shapes analysis in this study.

Pawson and Tilley's methodological pluralism does not equal a '*bit of this or bit of that*' approach (Pawson & Tilley, 1997, p. 154), they are clear that pluralism is couched within a rigorous methodological approach (Pawson, 1996). Regardless of the methods selected, a particular strength of Realistic Evaluation is the goal of 'cumulation' [see also section 3.3.3]. Realistic cumulation (Pawson & Tilley, 1997, p. 117-121) is another way of looking at the aims of research in the social sciences, to uncover findings that can inform further programmes, strategies and so on. Cumulation in Realistic Evaluation is the process of abstraction from the data, the identification of context-mechanism-outcome (CMO) configurations [section 4.2] and drawing conclusions about these, which can be applied outside the particular context and setting of the original research. In his study of youth mentorship (as distinct from mentorship in nursing education) Pawson (2004) demonstrated that evidence of the efficacy of programmes or interventions is usually mixed and suggested that exploring mechanisms and the contexts in which they take place could identify more robust explanations of a phenomenon. He described this as 'sensemaking', which should: "*explicate, spell out and make further sense of… formative ideas*" (Pawson 2004, p. 85). In line with the Realistic Evaluation Cycle [Figure 8, p. 72], results from this type of sensemaking can inform theories which can, in turn, inform future developments in the relevant fields which can then themselves be evaluated and contribute to further developments.

### *4.1.1. Data collection*

As set out in the Methodology chapter [section 3.6], three groups were approached for interview and students' practice documents were collected for documentary analysis. Further, two 'key informants' (KI) with different expertise, were approached to discuss and verify emerging concepts [section 3.6.4]. Table 2 on p. 78 summarises the data collected for each group. Each interview was transcribed[11] and studied to form a preliminary analysis before conducting the next interview.

Participants were assigned a code relating to their role (PEF, EC, M or KI) and the order in which interviews took place. Students' (S) practice documents were assigned numbers based on the cohort (September 2007 = 0907, March 2008 = 0308) and order in which they were analysed. In order to guarantee anonymity, practice sites and specific fields were avoided. Finally, as so few men work as PEFs or ECs and so few participated in the study, all interview participants are referred to as female in order to strengthen anonymity [see section 3.6].

In the Findings and Discussion chapters, in line with findings from Corden and Sainsbury's (2004; 2006) research into how and why qualitative researchers use quotes in research reports, quotes from participants are presented for a variety reasons. In this study quotes were used to illustrate theoretical concepts, to provide a voice for participants and to provide evidence of analysis of the whole data set [further discussed in section 8.1.5]. The language of the quotes (from interviews or comments from documents) was altered only to reduce detection of a particular accent or style of English and to correct obvious grammatical errors. Clarifying notes or definitions added to quotes are placed within square brackets []. Long pauses in interviews are noted by … whereas text that has been edited out is marked by […]. It should be noted that not all participants are quoted equally. PEF03 was particularly critical of the ISP, especially in her second interview and thus appears frequently in sections challenging each CMO configuration. Other participants, such as M01 and M04 were particularly confident mentors who spoke

[11] Recordings of interviews with PEF05 and M11 were lost due to technical failure, therefore both interviews were written up after the interview (as soon as the recording failure was detected). Both participants were contacted, they each commented upon and agreed a reconstructed 'transcript' but their 'voices' are lost as the transcripts are reduced to statements largely remembered by me.

clearly and concisely, and whose ideas are therefore particularly quotable. Other participants expressed similar thoughts or perspectives but in a lengthier style that is difficult to capture without reprinting large sections of the interview [see also section on Limitations 8.1.5]. Despite unequal quoting, (for instance PEF06 is not quoted in the body of the thesis) no group of participants or particular interviews were privileged in the analysis. KI interviews were however used to check concepts arising from the initial analysis providing a different type of data [see section 3.6.4]. As mentioned in section 3.6.1 PEF04's data was not used in the analysis and M02's interviews [see section 3.6.3.] yielded data on assessing interpersonal skills *without* a tool to do so. Despite lacking transcripts from M11 and PEF05 [see Table 2 and footnote 11], an attempt was made to weigh their contributions equally.

After a lengthy back and forth process of inductive and deductive coding [expanded upon in section 4.2.1] at different levels on the 'abstraction ladder' (Smith & Liehr, 2008), four CMO configurations were identified with four main contexts, 13 mechanisms and two main outcomes [see Findings section 5.1.1 and Table 7, p. 108]. In chapter 6 these configurations are further abstracted to generate the 'spiral of raised awareness' [section 6.1] and middle range theories [section 6.2].

## 4.2. Context-Mechanism-Outcome Configurations

As discussed in the Methodology chapter [section 3.3], Realistic Evaluation's contribution to evaluation is to go beyond the question, 'does this work' but to attempt to answer '*what works for whom in what circumstances and in what respects, and how?*' (Pawson & Tilley, 2004, p. 1). In order to do this, data were analysed with respect to identifying context, mechanism and outcome. Context in Realistic Evaluation has been defined as: "[…] *the culture, resources, and opportunity structures which enable certain actions and constrain others*." (Pawson & Tilley, 1996, p. 575) or

> "[…] those features of the conditions in which programmes are introduced that are relevant to the operation the programme mechanisms. Realism utilises contextual thinking to address the issues of 'for whom' and 'in what circumstances' a programme will work." (Pawson & Tilley, 2004, p. 6).

The identification of mechanisms forms the heart of the Realistic Evaluation approach. A mechanism refers to a process identified as having been triggered by an intervention in a particular context leading to an outcome. Because of the critical realist background of Realistic Evaluation [see Methodology 3.2], the approach also insists that the researchers search for mechanisms that have not been triggered (relating to the constraining factors in context identified above). Pawson and Tilley have defined mechanisms as: *"*[…] *an account of the make-up, behaviour and interrelationships of those processes which are responsible for the regularity [of observed outcomes]*" (Pawson & Tilley, 1997, p. 68). They also emphasise the importance of the human response to mechanisms: "[…] *interventions work when the resources on offer (material, cognitive, social or emotional) strike a chord with programme subjects*" (Pawson, 2003, p. 473).

Finally, outcomes refer to the observed patterns of events or behaviours after an intervention has been introduced. Outcomes are not necessarily causally related to the interventions, and other factors that may have had an impact on the outcome must be examined. Due to particular contexts or mechanisms, outcomes may vary from situation to situation: "*Outcome-patterns comprise the intended and unintended consequences of programmes, resulting from the activation of different mechanisms in different contexts*." (Pawson & Tilley, 2004, p. 7). Pawson (1997, 2003) and Tilley (2000) are quite clear that Realistic Evaluation is a theory-based approach and that researchers come to their question with hypothesized contexts, mechanisms and possibly outcomes [see sensitising concepts section 3.10.1], but that empirical data is then used to refine (or reject) these, building ever more robust CMO configurations which themselves can be seen as middle range theories (Byng et al., 2005; Pedersen & Rieper, 2008).

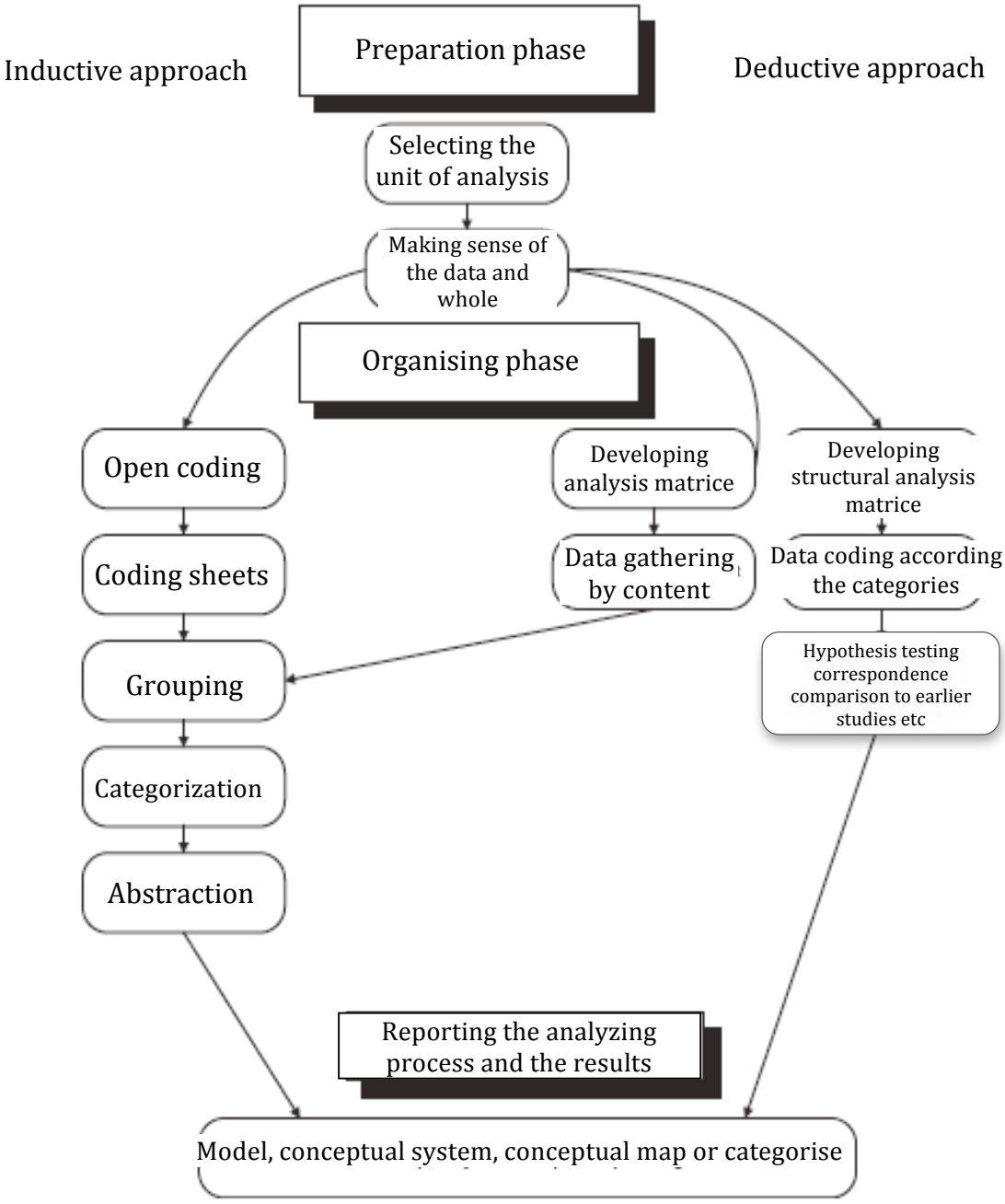
In line with Pawson and Tilley's theory based approach, notional mechanisms and contextual factors were developed through the Literature Review [chapter 2] and familiarity with the setting [section 1.3]. These 'sensitising concepts' (Bowen, 2006) [section 3.10] were used as a starting point for building CMOs in the data analysis

### *4.2.1. Analysis strategies*

The analysis process proceeded in fits and starts as interviews were transcribed and initial analysis was done. Using the AtlasTi qualitative data management software (version 6, Scientific Software Development 2007), transcripts were read and coded by grouping quotes into categories. For the documentary analysis, all written comments on the ISP were transcribed and entered into AtlasTi. Mentor and student comments were coded using the same categories as the interview data. Additionally, the items of the ISP selected for each assessment were entered into an Excel spreadsheet [Appendix E]. At various points throughout the data collection period, groups of transcripts were looked at together and a process of 'making sense of the whole' (Elo & Kyngas, 2008) was undertaken. If there was a gap between interviews, transcripts were re-read to increase familiarity. The process was 'retroductive' [see also Figure 11, p. 103]:

> "Retroduction can be seen as a 'real world' combination of the various 'ductions' […] Research is not pure with distinct stages of deduction, induction or abduction, but a combination of all three, often going on simultaneously. Retroduction is a term applied to this process that recognises its 'retro' or constant backtracking, nature." (Miller & Brewer, 2003 p. 3).

The first coding process was inductive and codes were labelled from reading and selecting quotes. After all data collection was complete the codes (40) were clustered and identified as: context (15), mechanism (15) or outcome (6) and four more descriptive codes that did not seem to fit neatly into either context, mechanism or outcome [see Appendix F for initial code list and definitions]. Using a deductive strategy the codes were then revised using the context, mechanism and outcome codes as a starting point and the data was revisited. After this iteration some categories were collapsed and others expanded, as definitions were refined. Codes were clustered together to form context, mechanism or outcome groupings [section 4.2.2]. Throughout, tactics suggested Miles and Huberman (1994) for both '*generating meaning*' and attempting to make those meanings '*valid, repeatable and right*' (p. 245) were applied. Interview data and mentor comments from the documentary analysis were used to challenge each CMO [sections 5.1.1.1, 5.2.4, 5.3.4, 5.4.4 and 5.5.4].




Preparation, organising and resulting phases in the concept analysis process

***Figure 11 Inductive and deductive analysis (reproduced from Elo & Kyngas 2008)***

### *4.2.2. Code groups*

The initial level of analysis was very close to the data and did not provide the level of abstraction necessary to support cumulation as an in-depth knowledge of the situation and background was required to understand the codes and clusters. After the completion of data collection and in order to look at aspects beyond the

particular study HEI and pre-registration nursing programme, data was abstracted to a second level and clustered into seven code groups organised around Context [two groups, Table 4], Mechanism [three groups, Table 5] and Outcome [two groups, Table 6]. Code groups consisted of first-level codes that had an impact on a particular aspect. There was occasional overlap with some codes playing a role in more than one group. For example, the code 'mechanism: explicit' seemed to encompass an impact on formative assessment of interpersonal skills in that students and mentors knew what was expected. This became part of a mechanism group 'mechanism: formative function'. 'Mechanism: explicit' also meant that mentors were provided with words to give feedback instead of having to generate words themselves. This aspect became part of the mechanism group 'mechanism: less daunting'. The third level of analysis yielded the CMO configurations summarised in Table 7 and discussed in chapter 5.

#### 4.2.2.1. Second level context groups

Realistic Evaluation distinguishes between background information and context [see section 4.2]. Background information refers to descriptive context or circumstances that provide information for readers of research. The second category, contexts make up the CMO configurations by facilitating or inhibiting mechanisms. In terms of cumulation and generalisability, context refers to the 'for whom' and 'where' (Pawson & Tilley, 2004).

| | Name of group | Codes included in context group |
|---|---|---|
| Context | Mentor variation | Context: clinical learning environment, mentor prep, ward, student, doc, pressure, mentor variation |
| Context | University and placements | Context: Uni changes, education champions, SLAiP, doc, situation prior, cluster skills, organisation of placements, PEF variation, interrupt/intermit |

***Table 4 Context groups after second cycle of analysis***

The two groups in Table 4 address different aspects of the broad contexts in which the study occurred. However, as context in Realistic Evaluation focuses on the specific context surrounding the programme or intervention, further analysis suggested that some of the contexts initially identified were not pertinent to the ISP tool, and others grouped too much together. The contexts making up the first group in Table 4, 'mentor variation' were kept through the third cycle of analysis

and abstraction and are discussed in CMO3: Clinical setting variability [section 5.4.1] and CMO4: Variability of mentors' experience and students' expectations [section 5.5.1]. The contexts in the second group, 'university and placements', make up background information and as such are described in this study [see Introduction 1.2 and Literature Review 2.3.1.1] but do not form part of the CMOs described in chapter 5.

#### 4.2.2.2. Second level mechanism groups

Mechanisms get to the heart of what it is about the tool or intervention that is having an effect. As Pawson and Tilley (1997; 2004) identify, the mechanism may not be immediately 'causal', i.e. it does not make the intervention work, but rather offers resources or opportunities to those engaging with the intervention so it can work. It is this process that is investigated in a Realistic Evaluation, and as such the research must also identify when the mechanism does not lead to an outcome or 'does not work'.

| | Name of group | Codes included in mechanism group |
|---|---|---|
| Mechanism | Facilitates | Mechanisms: Place to document, facilitates, prompts, quicker |
| Mechanism | Formative Function | Mechanisms: formative assessment, explicit, socialisation, borderline comments<br>outcomes: consequences, earlier improve and earlier fail |
| Mechanism | Less Daunting | Mechanisms: subjectivity, less daunting, identify what are attitudes/behaviours, emotional, distance, explicit<br>Outcomes: define pass/fail and consequences. |

***Table 5 Mechanism groups after second cycle of analysis***

The three groups of mechanisms formed during the second cycle of analysis [Table 5] focused on supportive aspects of the ISP and were found to be only part of the story after the third cycle of analysis [see chapter 5]. This second cycle of analysis was still quite close to the data and had not yet been abstracted to understand mechanisms that might be effective in any tool. Creating only three mechanism groups obscured differences amongst mechanisms and how they might have worked. In chapter 5, thirteen third level mechanisms are discussed, with an emphasis on 'explicitness' [5.2.2.1.] and 'clarity' [5.5.2.1] although the idea of 'distance' [5.3.2.1] incorporates the 'less daunting' group. Some of the mechanisms grouped into the mechanism family 'facilitates' are pulled out again and examined

in ‘a place to document’ [5.2.2.3] and ‘prompt’ [5.3.2.2]. The ‘formative function’ was grouped with summative assessment in the ‘consequences of assessment mechanism’ [5.2.2.4] and some of the ideas there were more relevant to the outcome of students ‘challenging’ and ‘changing’ [sections 5.5.3.1 and 5.5.3.2].

#### 4.2.2.3. Second level outcome groups

Because interventions are introduced into a variety of situations, outcomes will be mixed. Some mechanisms may be triggered in some contexts and lead to some outcomes, sometimes the context may mean than the mechanism is not activated and therefore no outcome or a different outcome is seen [see section 3.3]. Pawson and Tilley (1997; 2004) also acknowledge that despite best intentions, some outcomes are unforeseen, therefore analysis should also look for negative or exceptional cases.

| | Name of group | Codes included in outcome group |
|---|---|---|
| Outcome | Confidence | Mechanism: confidence<br>Outcome: confidence |
| Outcome | Interpersonal Skills Assessed | Context: of the prior situation<br>Mechanisms: formative assessment, earlier failing<br>Outcomes: earlier improving, consequences, interpersonal skills assessed, earlier fail |

***Table 6 Outcome families after second cycle of analysis***

The second level outcome family groupings remained fairly stable in the Findings [chapter 5] arising from a third cycle of analysis and abstraction. In sections 5.2.3.1 and 5.3.3 ‘Confidence’ continued to be categorised as both a mechanism and an outcome, and ‘interpersonal skills assessed’ remained a main outcome of the study, with the refinement of *overtly* assessed [sections 5.2.3.2, 5.3.3 and 5.4.3]. An additional outcome group emerged during the third cycle of analysis, relating to students’ opportunities to challenge unfair assessments, improve their performance or, if appropriate, fail and exit the course at an earlier point [see sections 5.5.3.2 and 5.5.3.1].

### *4.2.3. CMO configurations*

Following the development of the code groups, during a third cycle of analysis and abstraction, the CMO configurations were built. As the contexts, mechanisms and

outcomes were put together, further duplication of categories or redundancies of coding became apparent. After several iterations four CMOs were conceptualised [see Appendix G for an example of diagrammatic representation of conceptualising CMOs and an early example of a CMO]. There is no guidance on presenting findings in Realistic Evaluation and many published examples focus on the mechanisms uncovered (Jolly et al., 2009; Melton, 2009; Pommier et al., 2010) or present the context, mechanisms and outcomes separately (Leone, 2008; Long, 2009; Hogg, 2010; Rycroft-Malone et al., 2010). However, in my understanding of Realistic Evaluation, the interaction of the context, mechanism and outcome in a configuration was important and the three aspects could not be presented separately. The contexts, mechanisms and outcomes for each CMO, which emerged from the abstraction and testing of the third cycle of analysis, are listed in Table 7 [p. 108]. In the following Findings chapter each element in Table 7 is examined and challenged.

## 4.3. Fourth level of analysis

Data analysis and abstraction continued after the initial findings with the development of theoretical models [chapter 6]. The interconnectedness and interdependence of context, mechanism and outcome were theorised in a 'spiral of raised awareness' [section 6.1]. Three middle range theories were abstracted [section 6.2]. These encapsulate mechanisms which are likely to be pertinent in other contexts. The theoretical models developed in the fourth level of analysis contribute to knowledge as discussed in section 8.3.

## 4.4. Data Analysis conclusion

Data analysis in Realistic Evaluation is not prescribed. This study followed a retroductive process of inductive and deductive coding, clustering and theory generating guided by Elo and Kyngas (2008) and Miles and Huberman (1994). The interaction of context, mechanism and outcome is important in Realistic Evaluation and four CMO configurations were developed and tested.

| | Context | Mechanism | Outcome |
|---|---|---|---|
| CMO1 | Interpersonal skills are hard to assess Ephemeral, not sure university wants this information, feels judgemental/uncomfortable | **Explicit-** what/when to assess **Permission to assess** – mentors are allowed to assess **Place to document** –there is a place to capture comments **Consequences of assessment-** seen by mentors and students | *Interpersonal skills overtly assessed* May have been done before but not clear to student or possibly the mentor themselves (mechanism for CMO4) |
| CMO2 | Mitigating mentor weaknesses Junior status, required to mentor, lack of confidence, inadequate preparation, one-to-one assessment | **Distance** –less personal, less judgemental, less emotional **Prompt** –raise awareness, trigger **Legitimises**-backup not alone | ***Increase in mentor confidence*** Mechanism support to openly assess interpersonal skills (mechanism for CMO1) |
| CMO3 | Clinical setting variability Variations in clinical areas, pressures, variable learning opportunities, field variations, organisation of placements | **ISP as leveller and enabler** Everyone has to assess, words provided, easier, faster | *Interpersonal skills overtly assessed* Assessed in all settings; regardless of differences in implementation (mechanism for CMO4) |
| CMO4 | Variability of mentors' experience and students' expectations Differences in mentor, mentor experiences, who the student is | **Clarity**- expectations outlined awareness, **evidence** provided for choices **Feedback** both formative (motivational) and summative (**consequence for student**) | *Student can challenge*, can challenge assessment *student can change* can learn from feedback Increased transparency (mechanism for CMO1) |

Key: Contexts are underlined, **Mechanisms** are in **bold,** *Outcomes* are in *italics,* ***Mechanism/outcome*** is in ***bold and italics***

***Table 7 Contexts, mechanisms and outcomes for each configuration after third cycle of analysis***

# 5. Findings

## 5.1. Findings overview

As a methodology, Realistic Evaluation asks the questions, what works for whom, and why? [see section 3.3.1]. The aim of the analysis in Realistic Evaluation is to look for mechanisms that may be at play and which may be transferable beyond the particular context and situation in which the study took place. A criticism levelled at Realistic Evaluation is that the 'linear' relationships between context-mechanism-outcome (CMO) configurations are over-simplified and cannot handle complex situations (Davis, 2005; Hansen, 2005; Dickinson, 2006) [further addressed in the Discussion 7.2]. However, in any process of data analysis and abstraction we are tasked to pull salient factors from a sea of possibilities (Sandelowski & Barroso, 2003; Elo & Kyngas, 2008). In this study, addressing the complexity of the situation, four interrelated CMO configurations have been identified from repeated reading and cross-checking of the data [see section 4.2.3].

This chapter introduces the findings, recapping some of the methodology and framing the presentation of each CMO. Subsequent sections provide detailed evidence for each of the contexts, mechanisms and outcomes abstracted from the data [see Table 7 p. 108], presented in four interconnected CMO configurations [see Figure 12, p. 110], each named after the main context. Mechanisms and outcomes may be repeated in different CMO configurations; however, different aspects are emphasised in each. In keeping with the methodology of Realistic Evaluation, each CMO is also challenged looking for negative cases and examples of how a mechanism may not have been triggered or may not have been effective. Section 5.1.1.1 presents an introduction to challenging mechanisms and a general challenge to all CMO configurations. Quotes from participants are used to illustrate themes and provide examples for the reader [see sections 4.1.1 and 8.1.5] and are used throughout the Findings and Discussions chapters. Section 3.6 on p. 77 provides a summary of categories of participants.

### *5.1.1. Four Context-Mechanism-Outcome configurations*

From the analysis of interviews several mechanisms were identified that transcend the particular situation of one pre-registration nursing programme in an English HEI. In attempting to tease apart the complex threads that make up the assessment of the interpersonal skills of pre-registration nursing students by clinical nursing mentors in the practice setting there is necessarily some overlap. For the purposes of clarity, the four configurations are presented separately but are cross-referenced to signpost between the configurations and to acknowledge the links.

To summarise [see also Figure 12, below]: CMO1 underpins the others and addresses the fundamental issue (identified as the context) that interpersonal skills are hard to assess [see also 2.3.2.1]. CMO2 focuses on mentors who were junior staff nurses, or unprepared for mentoring. CMO3 centres on the variety of placements and placement types in which mentorship and assessment takes place. CMO4 looks at the interaction between mentors (with their personal histories of learning and assessment) and students (with their previous experiences of practice settings and assessments by others).

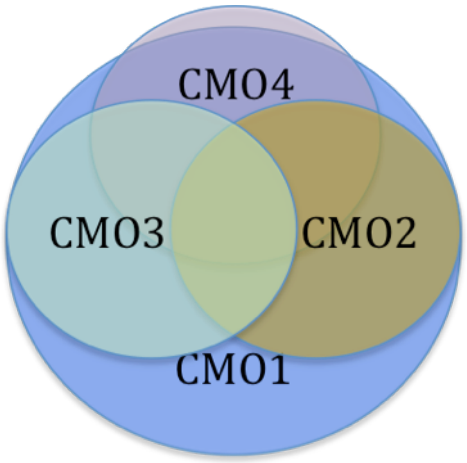



***Figure 12 Interconnection of CMOs, underpinned by CMO1***

The mechanisms (highlighted in bold throughout chapters 5 and 6) are presented within the framework of CMO configurations [see Table 7, p. 108] and in chapter 6 are addressed more broadly in the development of middle range theories [see section 6.2]. The figures of each CMO configuration are based on Pawson and

Tilley's diagrams [see Figure 13 below] in their seminal text (Pawson & Tilley, 1997).

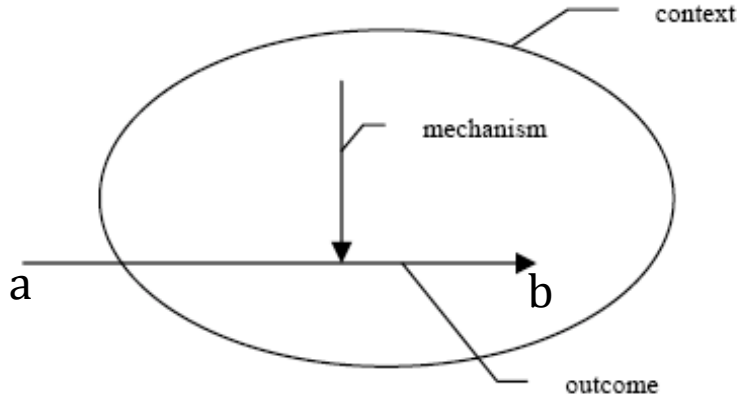



***Figure 13 CMO configuration***
***(adapted from Pawson & Tilley 1997, p. 58)***

The oval represents the context, the mechanisms are represented by the vertical down arrow while the horizontal arrow across the oval corresponds to the outcome, which should change from time a (prior to the mechanism) to time b (after triggering of the mechanism) [see also Figure 6, p. 65]. As discussed in the Methodology chapter [sections 3.2 and 3.3.3.1], not all mechanisms work all the time, and the outcome may *not* change from time a to b. These negative cases are explored in the section on challenges [section 5.1.1.1] and in each section on each CMO configuration. Figure 14 [p. 112] illustrates the interrelated nature of CMOs. For instance, the outcome of mentor confidence in CMO2 [5.3.3] is a mechanism in CMO1 [5.2.3.1]. The outcome that interpersonal skills are overtly assessed [in CMO1 section 5.2.3.1 and CMO3 5.4.3] is a mechanism for the outcome in CMO4 that students can challenge and students can change [section 5.5.3]. The pentagons in Figure 14 [p. 112] represent these intermediate mechanism/outcomes.

#### 5.1.1.1. Challenges to CMOs in Realistic Evaluation

In this study a challenge was a way to explore contexts that inhibit the firing of mechanisms (or that fire others, including those not identified in the study) where the outcome related in the original CMOs does not seem to be triggered. Each section on each configuration, for consistency and clarity, focuses on particular examples which challenge each CMO [sections 5.2.4, 5.3.4, 5.4.4 and 5.5.4]. However, the 'disinterested mentor' is a contextual factor that challenges all

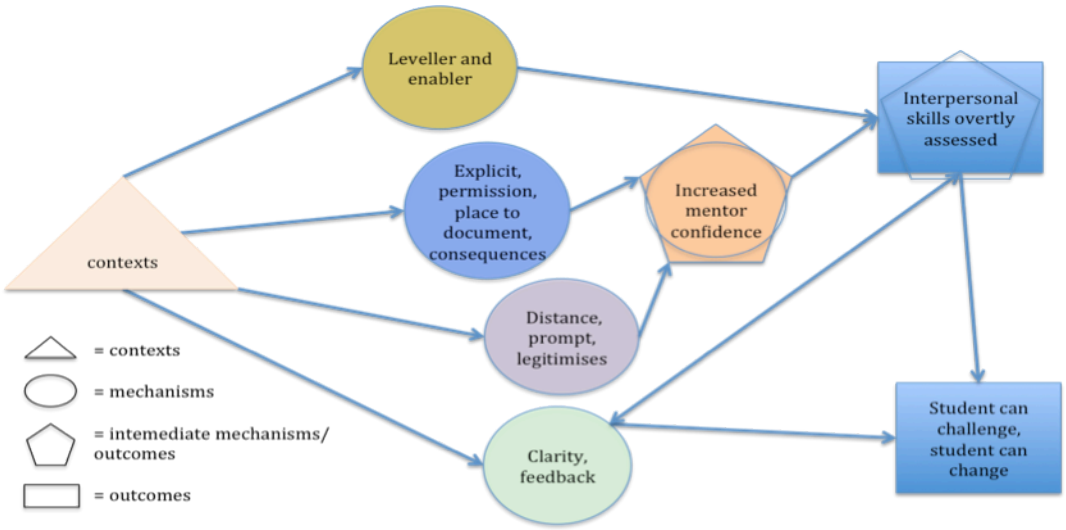



***Figure 14 Outline of CMOs with intermediate mechanism/outcomes***

mechanisms generated by the ISP. More than a weak or borderline mentor [see section 5.3.1], the disinterested mentor is uninterested in mentoring and unengaged with the student, and as key informant KI1 suggested, no tool would effectively support their assessments:

> P31: KI1 (63:64)
> KI1: […] I think if you've got a mentor who isn't effectively fulfilling the role of mentor and they are letting things drift, they are giving students the benefit of the doubt, they're not tackling issues I don't think any practice assessment document would deal with that, I think that's an issue for the mentor not the documentation…

In this type of case, if the student were to challenge their assessment, it is likely as KI1 suggested, it could be overturned at appeal due to poor completion of paperwork and lack of due process. Accurate documentation is also important to support mentors' decisions:

> P31: KI1 (45:45)
> KI1: […] if it's not written down it may as well not have happened, so if a mentor hasn't written those examples down, then the student on appeal will just say well they didn't give me any examples and unfortunately if the mentor has presented them verbally but not written them down then, they don't count really do they?

Unfortunately, assessments by disinterested mentors are more likely to generate a 'missed opportunity' where the student is graded in the middle range and comments are not helpful or constructive but as they have passed, the student does not challenge the assessment. As KI1 stated:

> P31:KI1 (17:17)
> KI1: […] by letting it drift, it's not even necessarily the issue that we've failed to fail a student that was unsafe it's perhaps that we've missed an opportunity to get the absolute best out of a student.

Disinterest in and disengagement with the student effectively neutralises the effects of raised awareness [section 6.1] as the mentor chooses not to focus on major aspects of the student's performance.

## 5.2. CMO1: Interpersonal skills are hard to assesss

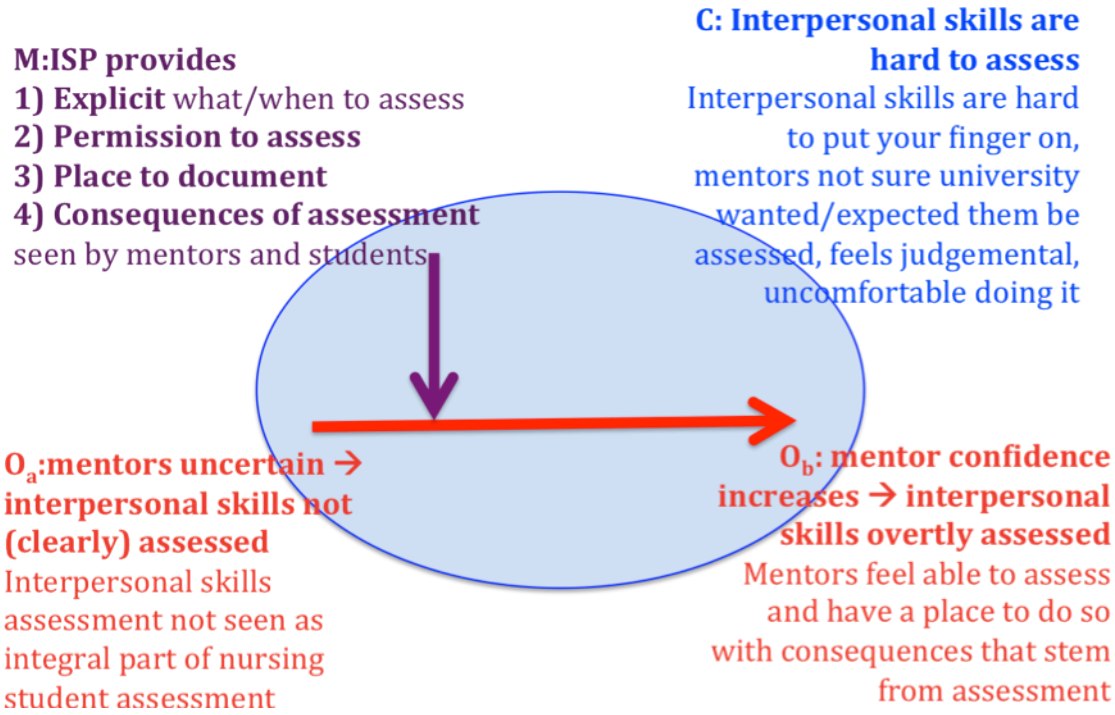



***Figure 15 CMO1: Interpersonal skills are hard to assess***

As identified earlier [section 5.1], the CMO configurations are interconnected and have been pulled apart for the purposes of analysis and discussion. CMO1 can be pictured as underpinning the others [see Figure 12, p. 110]. For instance, a mechanism that works for borderline mentors [see 5.3.1] will probably also be effective for confident and experienced mentors, all of whom work in variable practice settings [see 5.4.1.1] and have a variety of expectations [see 5.5.1.1], assessing students with a variety of experiences [see 5.5.1.2]. CMO1 focuses on the ephemeral nature of interpersonal skills themselves [see Literature Review 2.3.2.1] and the potential discomfort and challenge of assessing such time-bound and contextual behaviours.

### *5.2.1. CMO1 Context*

#### 5.2.1.1. Interpersonal skills are 'hard to put your finger on'

The ISP was introduced at the university based on anecdotal feedback from mentors in the practice setting, that interpersonal skills seemed different from clinical skills and more difficult to assess.

> P31: KI1 (3:3)
> KI: one of the key reasons why we've got the interpersonal skills profile is mentors would say, 'students are technically competent, they've got the underpinning knowledge but there is something I can't put my finger on, that I can't capture in the assessment document you know, something to do with their attitude or their manner', maybe they were concerned about the way they interacted with the patients or visitors […] so that's what mentors would often say, it's quite difficult to capture those things and I think they sometimes they felt they would end up passing a student without having had the opportunity to explore that, or also, not even just about pass and fail but about initiating discussion, that it's quite difficult, it's easy enough to say to somebody 'oh you're not really competent at taking a blood pressure this is something we need to set a goal for, something we need to address' as saying to somebody 'your manner with the patients isn't particularly caring' because it's a more personal thing, it's much harder to actually initiate that discussion so I think the mentors felt there was definitely a need for something to capture the things that the assessment documents weren't capturing.

Mentors also identified feeling uncomfortable commenting on interpersonal skills [see section 5.3.2.1 on **distance**]. M07 asserted that assessment of interpersonal skills outside a framework like the ISP might have appeared judgemental to students:

> P7: M07 (129:129)
> M07: Yes I would still [comment on interpersonal skills without the ISP] but I think it doesn't make it as formal and I think it is good to have it quite formal in this way still because it is…it makes it more constructive and I think…I don't know as a student you might think that it is less of a judgemental thing.

Many PEFs identified that mentors felt uncomfortable and judgmental giving negative or critical feedback, particularly around interpersonal skills. PEF07 said:

> P29: PEF07 (173:173)
> PEF07: I think mentors are always have a problem with failing people, I think the interpersonal skills is probably more difficult really, because nurses, from a skills point of view I think they are clear cut and make assessment on that and I think that interpersonal skills in terms of they have to struggle and make a judgement on people's attitudes, personalities and I think they do feel uncomfortable about it.

As M15 explained, this discomfort is sometimes ascribed to the inherent 'niceness' of nurses:

> P15: M15 (245:249)
> M15: […] generally speaking and this is a very general statement, I just think as a rule nurses like to be nice don't they? And it's very, very uncomfortable to fail somebody or even mark them low just a pass or something and it's just an uncomfortable position to be

in…

PEF01 suggested that as a consequence of this discomfort, mentors often left issues unaddressed as they passed the student along until the more stringent requirements at the end of the programme allowed attitude and behavioural issues to be captured:

> P20: PEF01 (156:156)
> PEF01: Yes, you would get the how on earth did the student get here syndrome? Because it wouldn't be until [final placement] that their attitude would actually contribute to fail them really.

#### 5.2.1.2. Does the HEI/university want this feedback?

Mentors described being unsure that the HEI (often referred to by mentors as the university) was interested in feedback and assessment of interpersonal skills. This context is related to the mechanism **permission** discussed in section 5.2.2.2, as mentors felt with previous assessment tools, they did *not* have permission. M11 specifically stated that prior to the introduction of the ISP she had been unsure the university wanted to know about a poorly performing student she had had. Explaining why she found the tool useful, M06 identified that it helped her become aware of what the university wants to be assessed:

> P6: M06 (87:89)
> M06: No I think this tool is very useful because otherwise, yes it helps us how to think about what we are looking at as opposed to just making up something if you know what I mean. It gives guidance and I think that has been very useful. It helps us to know what the University is looking out for and what they are wanting to see.

M03 described the statements as approved by the HEI, indicating that she felt they were permissible to use:

> P3: M03 (103:111)
> M03: …I think these [items] can be used because they seem to be the approved sentences. It is not going to be a shock when it is written because they are in their booklets

In a more startling example, M06 who had supported students for several years suggested that previously mentors did not have an impact on the students' progression through the course:

> P6: M06 (105:105)
> M06: Because we have got this added responsibility of having to pass or fail them, whereas before we didn't, nothing that we really said made a huge amount of difference in their progress of their course
> KM: As a staff nurse working with students on a daily basis your feeling was that what

> you said wasn't going to decide whether they passed or failed?
> M06: Yes, that was then, but I think now it has very much changed and I think that is a good thing

She partially attributed this perceived change to increased mentor training and preparation but also saw being clearly asked to pass or fail students on the ISP as playing a role. Although mentors have long had responsibility to pass or fail students clinically [see Introduction 1.2.1.2], PEF07 confirmed that M06's perspective was not unique:

> P29: PEF07 (223:223)
> PEF07: there are still some mentors out there who still don't see that it is their role to fail a person, and I think that has been a shock to me, and the other facilitators and to some of the mentors as well, well what did you think your role was? It is assessment…

### *5.2.2. CMO1 Mechanisms*

As this configuration is the most encompassing, four mechanisms are examined; **explicit**, **permission to assess**, **a place to document**, and **consequences of assessment** by which the ISP may facilitate interpersonal skills to be assessed (the outcome) in this context of uncertainty and hesitation.

#### 5.2.2.1. Explicit

The ISP might be supporting the assessment of interpersonal skills through clarifying what is expected from students, and what and when mentors should assess. The tool asks mentors to select five items they think best describe the student both formatively at the midpoint (halfway through) of the placement and summatively at the end [see Appendix A p. 255]. Prior to the introduction of the ISP, interpersonal skills might have been implicitly assessed, without the conscious awareness of either the mentor or the student. M04, a mentor who was not very enthusiastic about the introduction of the ISP, described how she thought she had previously assessed interpersonal skills more indirectly:

> KM: And before you had it [the ISP] did you talk about those kinds of things [interpersonal skills]?
> M04: Not necessarily so overtly, does that make sense? Because sometimes, … I would say 'once you have had more placements you will develop more confidently in doing' things. Indirectly I must have been addressing it but I wonder and it's difficult because I can't remember. If someone didn't communicate very well, if I –not avoided that—but it [communication] wasn't one of the things I identified, almost, you would look at a different aspect maybe of what you have picked out. You wouldn't say 'you don't communicate well in a team'. It is difficult, I can't remember.

The tool, through **explicitly** raising the issues, can change the focus of the assessment. M09 suggested that the tool allowed more holistic assessment of the student:

> P9: M09 (71:71)
> M09: […] I personally think a lot of what nursing is about is on [the ISP]. So I think yes you are looking at clinical signs and symptoms but you are also thinking of what the patient needs, you are thinking about how you treat them, how you talk to them, how you act, how you respond to others. I think it gives you chance to look at people holistically as well as looking at what clinically they are doing.

PEF08 argued that through being clearly identified in the document, assessment of interpersonal skills appeared less subjective:

> P30: PEF08 (71:71)
> PEF08: […] yes you can document your reason for saying it, but it does all appear very subjective whereas I think with this you're being asked to make objective choice of these statements and I think these are much more objective assessments than you had previously […] and then you have to justify what you've said, you can't just make something up you've got to justify what decisions you've made, what your choices were, but I think it's a much easier way, much more objective way of dealing with it

As identified in CMO4 [p. 164 where two students challenged their mentors' assessments], the ISP can be seen as a learning tool for mentors and students. PEF07 suggested this happened by clearly raising the profile interpersonal skills and the consequences of assessment:

> P29: PEF07 (201:201)
> PEF07: I think it probably highlights that it is just as important for mentors and students to be aware that students that can equally fail on clinical skills as well as interpersonal skills whereas before I think 95% mentors really focused on clinical skills and I think they forgot about the interpersonal […] so I suppose it just makes people aware, and raises the profile, and I think that it has gotten them to question their own opinions and interpersonal skills as well, of their own personal judgement really

#### 5.2.2.2. Permission to assess

Because the ISP requires mentors to assess interpersonal skills, mentors described feeling like the document then gave them permission to do so. Having **permission** from a third party –the HEI—through the document made assessing these ephemeral skills seem less personally attacking and judgemental. PEF02 clearly stated:

> P22: PEF02 (86:86)
> PEF02: […] because I think as I said at the very beginning when you see [the ISP] in black and white, it gives people permission to identify what the issue is

PEF08 built on this when she agreed that the tool allowed mentors to address behaviours that were difficult to define but are not desirable in a practising clinician, someone you would not want to nurse you or your own family:

> P30: PEF08 (69:69)
> PEF08: …they are the ones who are very, very good generally, generally pretty good clinically, not ones you're going to fail because of clinical skills and academically they are good they pass their academic skills but there is still something about them that you can't quite put your finger on but you know that there is….they aren't somebody you want to nurse you, they aren't somebody you want to nurse your family because of attitude, like the ones you ask to do something they roll their eyes all the time or… (KM so you think this allows those issues…) to be addressed it does,

#### 5.2.2.3. Place to document

The third mechanism in this configuration is very practical. Mentors identified that previously, even if issues had been identified and raised, there was nowhere to write them down or feedback to the student and/or university. **A place to document** was mentioned by several participants. M05 described how she struggled to document what was happening with a challenging student prior to the introduction of the ISP. As a confident mentor she had broached the topic with her student but had nowhere to document it:

> P5: M05 (61:65)
> KM: Do you feel like you tried to talk to her about things like her motivation and her initiative?
> M05: Oh yes.
> KM: But you didn't have a...did you have a place to document those issues?
> M05: No, that was when we had the...I was doing it all on A4 paper. I wanted a record, I have still got all of the emails, I have kept them now (KM: just in case), my ward manager had a student on the placement before who she had lots of problems with, not problems but she hadn't passed because she didn't feel that she was up to the standard, so she had had lots of meetings and I remember her saying to me that she had kept a file on everything, even if it was just a bit of scrap paper. [...] I did that, I wrote it on - not secretly I did it in front of her - I wrote it down and stuck it in a file with all of the emails between the tutor and myself about it all. I don't know how long I will keep it for.

EC4 made the link that not having a place to write comments down meant that mentors did not *have* to raise interpersonal skills and therefore did not do so. She suggested writing it down also made the issue more real and concretely important [see section 6.1]:

> P19: EC4 (41:45)
> EC4: I think before the documentation we had was that if you're not assessing something in a way it's hard to address it, so in the previous documentation that we had was that there would be spaces for the mentors to write about how they had progressed but really, it was sort of a generic progression rather than perhaps identifying any particular areas, so there were students who would turn up late, those students who would be off sick a lot, there would be students who were quite negative, but there was no way sort of purposively for mentors to write it and so in a way not having to raise it they didn't.

[…]
EC4: although those things area quite important to anybody who's a trained nurse there was nowhere of putting it in our previous documentation where now that we've got it, it makes it a very real issue now, that actually as a mentor it is about professionalism as well as delivering clinical care

#### 5.2.2.4. Consequences of assessment

The idea the assessment of interpersonal skills has consequences can be examined in several ways. Firstly, mentors found it significant that they could have an impact on students' progression through the programme. From a formative perspective, EC2 and M05 stated how important it was to be able to put a student 'back on track' or to help them build their confidence. They both suggested that although how the mentor delivered the feedback was important, the ISP could help frame the discussion:

P17: EC2 (139:139)
EC2: yeah I think the whole….you can actually do it in a very kind way because it doesn't mean that because somebody has adopted this attitude they can't be put back on track, I think this is a tool at formative assessment to actually say, did you know that sometimes you're really rude and arrogant to patients and staff?

P5: M05 (68:69)
KM: Do you think you would have had a formative use for this? That if you had been able to say to her early on "this is where you are" do you think she would have taken it as a judgement, 'that's it you lack confidence, and it's over?' Or do you think you could have turned it into 'you lack confidence and I'm going to help you develop?'
M05: I think the latter, the lacks confidence I'm going to help you develop. I think it is not necessarily about the documentation, this is a useful tool, but some of it is about how you say it. If I had gone along and said to her "I think you're all Fs...and I'm not sure how we are going to get along with this, I'm not passing you" I think that would have knocked her confidence. I think it is a combination between the two. I think this would have been, at the time, so much more helpful, definitely

PEF01 made the case that the ISP gave mentors a means to fail students summatively if necessary, which was important for students to take interpersonal skills seriously [see Raised Awareness 6.1, Discussion 7.4]:

P20: PEF01 (63:71)
PEF01: yes, it's also made a huge difference I think to the students as well
KM: why is that?
PEF01: because before you couldn't…if they could do the competencies you couldn't fail them because of their behaviour, because there was no way of doing it, you could only write it, you couldn't actually fail them because of it, but now a student can fail purely on personal profile alone. And I think the students are more aware of that
KM: ok, so do you think that's caused any changes in their behaviour?
PEF01: I think it's made it more positive behaviour; we're not getting as many behavioural problems. We do [have more problems] when they first come in but they soon settle, when it seems to be they actually realise they can fail on their behaviour alone

Two further aspects of the consequences of assessment are covered in CMO4 [section 5.4.5], with the mechanism **clarity** examining the notion of student awareness of the summative consequences of interpersonal skills assessment [in section 5.5.2.1.1] and **feedback** to explore the idea of rewarding students by selecting items from the good and excellent range on the ISP [in section 5.5.2.2].

### *5.2.3. CMO1 Outcomes:*

The main outcome is that interpersonal skills are assessed where previously they may have been assessed; either implicitly [see p116], or without the mentor and/or student being overtly aware [see p131]. As mentors increase their confidence to assess interpersonal skills (both an outcome of the mechanisms but itself a mechanism for the outcome of interpersonal skills being assessed, see section 5.3.3) so too assessment of interpersonal skills increasingly happens.

#### 5.2.3.1. Mentor confidence

Even experienced, interested and involved mentors who are engaged with the process of student assessment, may feel less confident assessing interpersonal skills. The ISP seemed to support mentor confidence two ways. Firstly, through making it clearer that interpersonal skills are a part of the assessment, thus giving the mentor **permission** to assess them. Secondly through providing **a place to document** the assessment –with graded options from fail through to excellent— allowing mentors to see that their assessment **has consequences**. Mentor confidence is both an outcome of the mechanisms listed above and a mechanism itself to ensure the overt assessment of interpersonal skills discussed below in 5.2.3.2 [see also Figure 14, p. 112]

M04, a confident mentor already, stated that she used the tool to initiate discussions with the student using it to anchor the discussion and orient the student:

> P4: M04 (106:106)
> M04: I usually use it as a tool to start up a conversation about...right, this is what I am going to look at, and this is why I am going to choose these particular…

PEF07 goes further making the point that as previous documents did not ask mentors to assess interpersonal skills [see section1.3.1.1 and 1.3.1.2], they did not feel comfortable to do so:

> P29: PEF07 (147:157)
> KM: do you think even now mentors are comfortable commenting on interpersonal skills?
> PEF07: I think they probably are based on the grid [the ISP]
> KM: so this [the ISP] has increased their confidence?
> PEF07: I think it has yeah
> KM: you think before they might not have felt confident in saying…
> PEF07: I think they didn't know how to say it before, I think how do you start that conversation with somebody? Especially when the document you are using doesn't actually say you have to assess the student on interpersonal skills

EC4 suggested that the tool could help the mentor manage a struggling student because the mentor could give both positive feedback and identify areas for improvement:

> P19: EC4 (61:61)
> EC4: it's a two way, it's the student's document, but to pass it they need to have the cooperation or the collaboration of the mentor but equally I think that the practice document can help the mentor in terms of them perhaps managing a student that is having difficulties, so it's not just about tick box because now it's competencies it's very easy to go pass, pass, pass whatever but actually if there is a student who is having difficulties then it's the mentor can almost use it as a tool to say ok, you've done all this, you've done really well on but actually on these competencies you're not doing so well on, lets think about how we can tailor your placement to deal with these ones or actually I've noticed when it comes to communication you're very withdrawn you don't initiate, let's use that

#### 5.2.3.2. Interpersonal skills are overtly assessed

The mechanisms identified in this configuration seem to support the overt assessment of interpersonal skills for pre-registration nursing students [also the outcome for CMO3 section 5.4]. M01 put it clearly:

> P1: M01 (34:34)
> M01: So actually to use this document is saying yes you can do those tasks that are required by a nurse, actually you have got really good skills and attributes that are valuable to nursing on this end of the scale, which will make you an excellent, kind, safe, caring nurse

As is further explored in the Discussion [section 7.4.1], this outcome allows for gate-keeping decisions about continuing on the programme and entry to the profession to include interpersonal skills and professionalism. M04 suggested that the tool could highlight students who were technically able but who could not communicate well:

> P4: M04 (115:118)
> KM: Do you think get students that are borderline sometimes? [...]

> M04: I haven't had one yet […] I think maybe that is where this [the ISP] would pick [it] up because you can have technically brilliant nurses who are hopeless at talking to people.

Furthermore, as KI1 summed up, assessment of interpersonal skills gave students an opportunity to learn about and improve their skills which make up an important but difficult to teach (Griffiths et al., 2012; Tsang, 2011) part of nursing:

> P31: KI1 (23:23)
> KI1: …But the real value of this I see is to use it as a way of increasing insight and self awareness by saying to learners, actually, 'you know you come across as'…because often the learner will say 'that's not what I feel', 'but actually this is how you come across and why might that be and what can we do about it?' and it's a real tool to facilitate that discussion and to encourage them to step back.

### *5.2.4. Challenges to CMO1*

In this study, mechanisms represent tendencies [see 3.2 p. 65] not hard and fast relationships. After presentation of context, mechanism and outcome in each CMO configuration, these tendencies are tested in sections called 'Challenges to', using data from interviews and the documentary analysis.

CMO1 is the overarching configuration for all mentors in all areas regardless of previous experience. The mechanisms here were that the ISP makes assessment of interpersonal skills **explicit**, gives mentors **permission** to assess them and a **place to document**. It is also clear that the assessment has summative **consequences** for the student and their progression through the programme (touched on in section 5.2.2.4 above).

Despite these tendencies for mechanisms to support assessment of interpersonal skills, countering the suggestion that the ISP is a panacea, PEF03 noted that some mentors still found it difficult to make a judgement call on students' attitudes and behaviours:

> P24: PEF03 (149:149)
> PEF03: […] some staff really like [the ISP] they really like it they think it's great, they're halfway through they get to pick 5 categories and…other people find it very difficult to make that kind of judgement call and they tie themselves up in knots and they make a judgement call. Other people need some interpretation,

M06 said that she and other staff sometimes struggled to find different descriptors for the formative and summative assessments, but that eventually she realised it was not necessary to do so:

P6: M06 (77:77)
M06: I find [the ISP] quite useful but like with all these things I find it quite limiting in the sense that I know that mentors have said to me that once they have done the first interview, got your first, you have chosen five, then you do it again later on towards the end of it, I find they say that they are not sure that they can find another five. They looked further in those first five. I think they feel that they need a new lot because they have already said that. I think that is about the only area that people have struggled with. Once they know how they can use it I think we have found it to be quite useful. It is a good guide.

The tool makes assessment of interpersonal skills explicit and seems easy to use, but there was variation in understanding of how it should be used:

P24: PEF03 (210:210)
PEF03: …it slightly worries me that there is real variation…
KM: are there any you could say offhand that…
PEF03: lacks maturity [item 13], always a problem
KM: because what you were saying about age?
PEF03: people get maturity against age and I think the other one that they have problems is the lack of confidence inhibits effective performance [item 9] they confuse confidence with competence, and taking responsibility appropriate for this level [item 8] especially for third years they didn't know what was appropriate responsibility and it was the specialism taking over

However, PEF01 and M10 identified other ways to deal with the ambiguity inherent in the ISP. PEF01 suggested that mentors select the items to reflect the outcome they want to convey to the student:

P21: PEF01 F-up (17:20)
PEF01: They tend to use those [slow to settle, has not achieved full potential, needs to be more assertive] rather than lack of confidence because if they put lack of confidence in the second and third year then they fail.
KM: So they find another way to say it?
PEF01: They find other ways round that doesn't fail them. That has been some of their comments that one or two of them that would fail them in the second and third year that it is possibly a little bit harsh because some people do lack confidence longer than just one year. They lack confidence in the first half of every placement so there are interpretations problems there and there are issues around the double assessment on those ones that have got the pass/fail on them.

Demonstrating this principle, M10 discussed a third year student who had been out of the acute setting for a while and who had lost confidence. She explained how she planned to give the student feedback without failing her:

P10: M10 (146:151)
KM: You're saying she does need more experience because she has been out of the hospital, would you pick that one? Or would you focus on something else do you think? Do you know what I mean?
M10: Yeah, yes I tend to, I try to use sort of a selection of them to try and cover… because they sort of fall into different categories on there, the time management and there's confidence ones, and there's ones sort of working above and beyond and that kind of thing. I try and select a variety of them but I wouldn't hold the fact that she has been out in the community against her, I would probably…
KM: You'd pick something else.
[…]
M10: Yes, I don't want to fail her as a student so I wouldn't pick anything that failed her.

As with the mechanism, **legitimises** in CMO2 [see section 5.3.2.3], it is difficult to find evidence to challenge the mechanism of permission to assess interpersonal skills. Presumably, where mentors still feel uncomfortable assessing interpersonal skills or have difficulty writing them down, they do not feel that they have the permission to do so. Thus when interpersonal skills are not assessed, mentors did not feel able to do so. This idea is further explored in 6.2.5.

While mentors and other participants talked about the ISP as a place to document behaviours and attitudes of student nurses, the documentary analysis [see section 3.8.2] suggests this was not always done. It is impossible to know what was not included in the documents by mentors, but examples such as S090711's[12] module 5 [beginning of second year] summative assessment can provide an insight. The mentor gave a generally positive assessment, selecting one good[13] (35) and four pass (26, 29, 27 and 28[14]) items alongside the comments:

> MENTOR: [The student] has worked with various members of the team identifying learning needs, working towards them and evaluating/reflecting on her experiences in a very mature fashion and has shown good theoretical understanding underpinning her practice. She has fitted in exceptionally well and been handing over to other members of the team also.

However, in the 'to be developed' area of the ISP her mentor wrote:

> MENTOR: […] although confidence has grown immensely during this placement, it is an area for her to continue to work on, a little self-belief is required- a very capable student.

This is a positive and constructive comment, however, at the midpoint there has been no mention of a need to develop confidence either in the items selected or in the written evidence. The student may have been aware of her mentor's assessment of her confidence, or she may not have. Any issue surrounding confidence has not been previously documented. However, it does seem that the

[12] Students in the documentary analysis are identified by location (A, B or C) and cohort, 09/07 or 03/08 and number in which their document was analysed 01-06 [see section 4.1.1]

[13] The ISP has 39 items scored f = fail, p= pass, g= good and e= excellent. Some items change categories [p to f, g to p, e to g] between first and second years. Refer to Appendix A p. 265 for detail on items of the ISP

[14] *Item descriptors will be provided in footnotes if they do not appear in the text:* 35 shows a mature understanding; 26 is able to reflect on outcomes; 29 shows a good understanding of the concepts of nursing; 27 identifies own learning needs; 28 has made a useful contribution to the work of the team

ISP, through having a 'to be developed' section in the summative assessment, did eventually allow for the issue to be noted and written down.

The final mechanism in configuration CMO1 was that of consequences of the assessment in terms of their progression through the programme. This was difficult to challenge through the interview data or comments. A proxy is to look at how items were selected in the documentary analysis, as illustrated by Table 8 [p. 126]. Even considering that students who submitted documents were probably above average in practice [see section 3.8.2], it seems that the lower items on the ISP were more often used formatively than summatively. Two possible explanations are that a) this group of students improved after getting critical feedback or b) that mentors still hesitated to select items that had negative summative consequences for the student. That mentors were rewarding students by selecting items in the good and excellent range [addressed in CMO4 section 5.5.2.2] can clearly be seen with items that are graded excellent being selected even from the first formative assessment.

#### 5.2.4.1. Unintended consequence of the ISP CMO1

In the search for challenges to the CMOs unintended consequences were also uncovered[15]. In CMO1, some senior management respondents mentioned that they use the ISP or statements from it for the evaluation of trained staff. An example is given by M03 who explained:

> P3: M03 (58:59)
> KM: You said you used this to give them [qualified nurses] feedback, how does that come up for the ones that are [qualified] because it is not in their documentation?
> M03: No it's not, but I kept a copy of it because I perceived these as being approved sentences whereas when you are giving less than positive feedback it is quite hard for me to find the words. I can say it, because I think tone gives an element of compassion. Even if it is not perhaps the nicest thing you want to hear, maybe your tone and body language can make it less damaging.

The tool was implemented for use with pre-registration nursing students; this application to trained staff was not expected.

[15] Unintended outcomes will also be explored in each subsequent CMO.

| * | 1/ 2F | 1/ 2S | 3 F | 3 S | 4 F | 4 S | 5/ 6F | 5/ 6S | 7F | 7 S | 8F | 8S | Notes about use of ISP items | Item themes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1-7 | | | | | | | | | 1 | 1 | | 1 | Generally not that frequent more formative , one student failed mod 7/8 | 3.negative attitude 5. motivation |
| 8 | | | | | 2 | | 1 | | | | | 1 | 1 to 15 | responsibility |
| 9 | 2 | | 1 | | 1 | | | | | | 1 | | Confidence raised for some, ALL formatively | Confidence |
| 10 | 1 | | 1 | | | 1 | | | 1 | 1 | 1 | | One case of 8 and 13 used form in module 5 (CB090702) | |
| 11 | | | | | | | | | 1 | 1 | | | and improved | |
| 12 | 2 | | 1 | | | | | | | | 1 | | | |
| 13 | | | | | | | 1 | | | | | | | maturity |
| 14 | 3 | 1 | 2 | | | | | 1 | | | 2 | | | assertive |
| 15 | 1 | | | | | | 1 | | 1 | 1 | | 1 | | |
| 16 | | | | | | 1 | 1 | | 1 | 1 | 2 | 1 | Potential raised in 2nd year | |
| 17 | 5 | 2 | 6 | 3 | 4 | 3 | 4 | 2 | 1 | 1 | | 1 | Willingness to try more acknowledged in 1st year, form | |
| 18 | 10 | 6 | 3 | 4 | 4 | 6 | 4 | | 3 | 1 | 4 | 2 | Devel confidence more in 1st yr, recurs for some, form | Confidence |
| 19 | 7 | 4 | 4 | 2 | 3 | 5 | 7 | 1 | 3 | 1 | 3 | 1 | Obv. Statement, used more in 1st yr and formatively in 2nd | |
| 20 | 5 | 3 | 3 | 5 | 3 | 4 | 5 | 1 | | 2 | 3 | 2 | Assimilation of info more rec'g in 1st year equal f/s | |
| 21 | 4 | 3 | 3 | 6 | 3 | 4 | 4 | 4 | 5 | 2 | 4 | 3 | Accepting responsibility fairly even summative | responsibility |
| 22 | 8 | 5 | 6 | 5 | 5 | 4 | 7 | 6 | 5 | 2 | 5 | 3 | Fitting into team more 1st year form | Team |
| 23 | 9 | 8 | 6 | 6 | 10 | 4 | 7 | 3 | 7 | 4 | 4 | 3 | Pleasant and approachable manner more 1st yr, formative 2nd | |
| 24 | 3 | 6 | 3 | 1 | 3 | 3 | 6 | 5 | 6 | 3 | 6 | 5 | Mature attitude more mentioned in 2nd yr, f/s | Maturity |
| 25 | 9 | 6 | 5 | 1 | 7 | 4 | 9 | 8 | 9 | 2 | 6 | 3 | Motivated and adaptable even, more formative | Motivation |
| 26 | 3 | 5 | 4 | 7 | | 3 | 8 | 13 | 3 | 2 | 2 | 3 | Able to reflect on outcomes, form & summ 1st yr, formative 2nd yr | Reflection |
| 27 | 6 | 10 | 10 | 5 | 9 | 6 | 10 | 8 | 8 | 2 | 7 | 2 | Id's own learning needs form even both, imp summ in session 1 | Learning needs |
| 28 | 5 | 9 | 4 | 8 | 7 | 7 | 4 | 6 | 5 | 4 | 2 | 5 | Contribution to team, more 1st yr, summ | Team |
| 29 | 2 | 10 | 4 | 2 | 2 | 6 | 4 | 4 | | 4 | 2 | 4 | Concepts of nsg summ imp in 1st year, more summ also in 2nd yr | |
| 30 | 2 | 7 | 5 | 7 | 6 | 7 | 6 | 7 | 6 | 8 | 7 | 8 | Increased from form session 1...form and sum use | Confidence |
| 31 | 1 | 3 | 2 | 2 | 1 | 2 | 2 | 3 | 2 | 2 | 5 | 4 | Most in end 2nd yr, f/s | |
| 32 | 2 | 3 | 2 | 3 | 2 | 3 | 5 | 4 | 3 | 5 | 2 | 5 | Increased, esp summ session 4...opinions (?expect 1st yr) | |
| 33 | 3 | 3 | 2 | 6 | 1 | 2 | 3 | 8 | 4 | 3 | 6 | 3 | Eval own performance even, ?form/sum, community? Mod 5 | |
| 34 | 1 | 1 | | 2 | 1 | 1 | 1 | 4 | 3 | 4 | 1 | 5 | More sum 2nd yr, ?expectations of 1st yr, decision-making | |
| 35 | 2 | 5 | 6 | 6 | 3 | 2 | 2 | 7 | 7 | 5 | 6 | 6 | Even, sum | Maturity |
| 36 | 2 | 8 | 1 | 1 | 4 | 4 | | 4 | 2 | 11 | 3 | 9 | More summative, more used session 1 and end 2nd year | Team |
| 37 | 1 | 1 | | 1 | | | | 1 | 1 | 2 | | 1 | Even...more 2nd yr? summ | |
| 38 | 4 | 1 | 2 | 6 | 1 | 2 | 2 | 4 | 2 | 8 | 4 | 5 | Summative 2nd yr? f/s | |
| 39 | 2 | 1 | 1 | 2 | 2 | 1 | 2 | 1 | | 3 | | 4 | Summative 2nd yr? summ | |

**Table Key:**

*= item numbers of the ISP

F= formative

S= summative

Top row: modules 1 -4 first year

5-8 second year

Modules 1 and 2 combined due to organisation of assessments in cohort 09/07

Items 1-7 infrequently used therefore combined

***Table 8 Use of each ISP item per module in first and second year***

### 5.2.5. Conclusion CMO1

This section explored four mechanisms by which the ISP might facilitate the overt assessment of interpersonal skills, which are notoriously ephemeral and difficult to pin down. That mentors are **explicitly** asked to assess interpersonal skills both formatively and summatively gives them a sense of **permission** that it is a part of nursing practice. The tool also gives them a **place to document**. The **consequences of assessment** are real, both formatively [addressed in section 5.5.2.2] and summatively. Challenging these mechanisms it was apparent that the tool is not as explicit for all users indicating that some users may require more specific support and/or instruction on its use [see section 7.8]. Nor, was the documentation always clearly, or thoroughly done [see section 7.6.1]. This configuration has laid the groundwork for mechanisms explored in subsequent sections.

## 5.3. CMO2: Mitigating mentor weaknesses

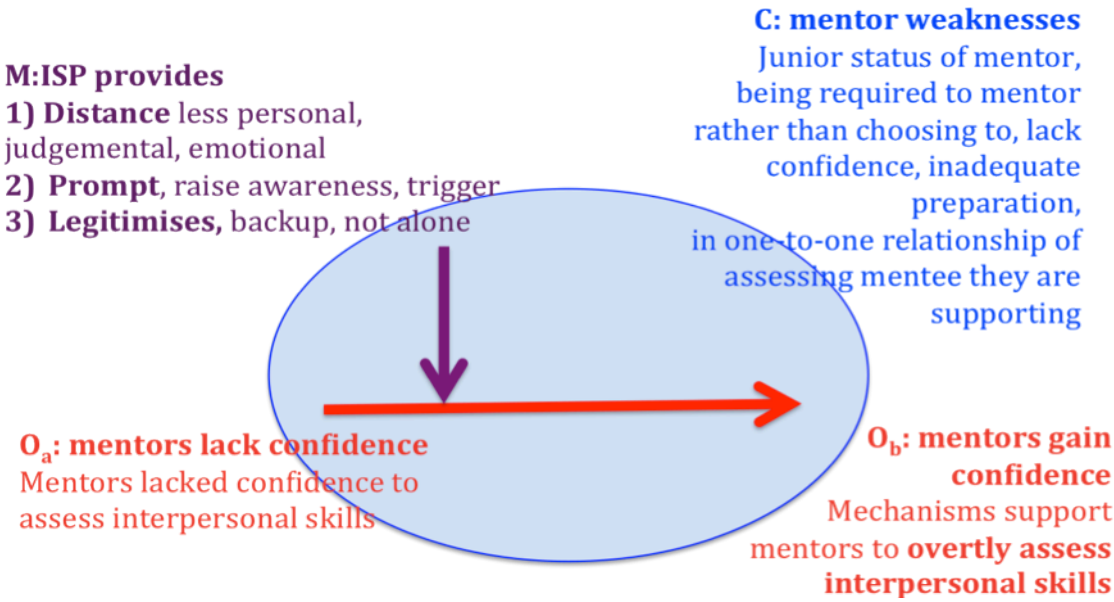



***Figure 16 CMO2 Mitigating mentor weaknesses***

### 5.3.1. CMO2 Context

The focus of CMO2 centres on those mentors who are not confident, who are ill prepared, who have not chosen to be mentors but have become so out of necessity and/or who are junior staff and who are learning their roles in the clinical areas as

well as developing their mentorship skills. During a discussion on borderline students [see section 5.5.1.2.2 ], KI1 coined the term 'borderline mentors' to describe struggling mentors:

> P31: KI1 (97:97)
> KI1: I guess it's where you've got a combination of a borderline student who's had borderline mentors, because if you've got good mentors they will respond to borderline students, if you've got good students then it won't matter that they've got borderline mentors, it's that combination with a student who's on the edge who hasn't encountered a mentor with the confidence to actually deal with it.

Despite acknowledging the existence of a group of mentors for whom no tool will make a difference as they should probably not be supporting students [see section 5.1.1.1], KI1 also described borderline mentors as being on the cusp, indicating that they could learn and develop their mentorship skills over time, and the ISP may support them in doing so:

> P31: KI1 (65:65)
> KI1: yeah I suppose if we talk about students being on the cusp, I suppose it's mentors that are on the cusp as well and the ones that aren't really…there are some mentors who are absolutely fantastic, there are some to be honest, who I think are really not fulfilling the role effectively at all and probably shouldn't be mentors and then there are some that are probably doing their best and bumbling along a little bit and again and again I think the bumbling along ones this [the ISP] probably guides them and directs them in a positive way, it gives them more scope and more guidance on how to effectively fulfil the role.

Mentors themselves identified that there were those who did not fulfil the role effectively. M11 reported being one of the minority of mentors in her clinical area who took an interest in students. Despite describing herself as an interested and dedicated mentor, M11 also identified deficits in her own confidence and preparation stating that the students were sometimes almost 'teaching' her to use the documents and that she had insufficient time to thoroughly read them. M10 suggested learning to deal with struggling students only comes through experience:

> P10: M10 (51:51) I think you only learn through seeing a failing student and having seen one I think if I got one I think I would be a lot more confident to address it, having seen how they [more senior staff] managed it.

Other mentors described themselves as confident, but recalled periods before they became experienced and their confidence had increased:

> P14: M14 (101:101)
> M14: yeah, probably, because before that when I first started mentoring there was a student who was rubbish basically and I didn't have the confidence to fail him then, he did

> actually go on and fail in another placement but I wouldn't have had the confidence then whereas I would definitely would now, having gone through the experience

EC4 also identified a group of mentors needing to develop in confidence and suggested that learning to become a mentor was a process:

> P19: EC4 (61:61)
> EC4: […] but I think also those skills come with mentoring more and more…. (KM: confidence…) yeah, I think with mentoring it's like caring for patients, if you have one of those patients where everything is going very easily and you love it, it's great, when you have challenging patients or challenging students you realise there is actually a lot more to the role and you have to pull on different skills but then when you discharge those patients or the students moved on, then when you have your next student or your next patient you realise what you've learned, so it's an ongoing process too

PEF02 identified that in addition to needing confidence and experience, many mentors were poorly prepared to support struggling or failing students:

> P23: PEF02 F-up (21:23)
> PEF02: No, I mean more basic than that [mentor's ability to give feedback] ok, I mean do I know how to complete the booklet? I mean, do I know how to fail a student? Have I been shown? Do I know what the paperwork looks like? Do I know which bits I have to complete on what date? I'm not talking about high-faluting assessment strategies at all, I'm talking basics.
> KM: Okay, and have you been noticing in the past nine months then that there are mentors who are struggling with this?
> PEF02: I wouldn't say I have been noticing it in the last nine months, I'd say I've been noticing it in the last [many] years since I have been doing this job.

#### 5.3.1.1. Closeness of mentor-student relationship

Borderline mentors, supervisors or assessors probably exist in most professional settings (Luhanga et al., 2008a; Govaerts et al., 2011) however, mentors in nursing and some other healthcare settings operate within a particularly close relationship with the student (Stuart, 2007) sharing their shift patterns, breaks and (in the case of community nursing) their cars. This proximity of space and time can make the challenging process of assessing students more complex and uncomfortable, especially for borderline mentors. For example M13 had challenged a student who had tried to get other mentors to sign her books, after this, while still needing to teach, support and assess this student, the atmosphere between them became more uncomfortable:

> P13: M13 (36:36)
> M13: she was just very quiet and in fact, after that [incident where student tried to get her practice document signed off by other mentors] she'd sort of stare at me in the staff room, I'd be sitting there eating my lunch and she'd be there eating her lunch and I'd just feel that she was looking at me, …it was really uncomfortable

Borderline mentors have to learn to mentor better and support their students. At the time of data collection, other measures were being introduced [see section 1.2.1.3] such as an increased profile of mentorship and mentorship preparation, a second edition of the NMC Standards to support learning and assessment in practice (SLAiP) guidelines (NMC 2008b) and improved effort on the part of the clinical areas to ensure the mentor register was up to date and accurate. While acknowledging these changes one mentor also identified that failing students and even providing critical feedback might still feel alien to some mentors:

> P1: M01 (48:48)
> M01: […] it would be interesting to compare because I think as a mentor we get so much more support now in failing students, that it doesn't feel so scary. I think that because of the new mentorship course and the fact that when you have to submit your essay you have to put in about failing students and it is one of those things as a mentor that is being raised. Maybe the future mentors may feel more comfortable because it is not as alien to them

Despite these changes that also support borderline mentors, there is evidence that some mechanisms associated with the ISP might also support borderline or struggling mentors.

### *5.3.2. CMO2 Mechanisms*

Three mechanisms forming part of the larger mechanism **clarity** [other aspects addressed in sections 5.5.2.1 and 5.2.2.1]—although important for all mentors of any level of experience, skill or confidence—with a particular influence on borderline mentors are discussed. **Distance** is considered in terms of de-personalising interpersonal skills assessment and taking away some of the responsibility and sense of being judgemental from the mentor. **Prompt** taps into the aspect of the tool that reminds, triggers and raises awareness of interpersonal skills and their assessment and **legitimises** refers to those elements that provide inexperienced mentors with a sense that they are not alone.

#### 5.3.2.1. Distance

Assessing interpersonal skills of students who work daily or regularly with mentors can be difficult due to the closeness (in proximity and perhaps emotionally) of the relationship. Two mentors suggested that assessment of interpersonal skills could be perceived of as a 'personal attack', M15 identified that

the ISP provided some distance from that personalisation and increased the constructive nature of the feedback in various ways:

> P15: M15 (176:177) […] (249:249)
> KM: so you're comfortable to raise those [issues like professionalism, attitude, appearance mentioned by M15], you don't need this to support you in raising them?
> M15: no, not um…when it comes to attitude and behaviour then yes I would need this because trying to say to somebody that their attitude towards the doctors or the patients or whoever isn't correct is quite difficult because it's a personal attack isn't it, saying to someone you're not allowed to wear a watch, that is hospital policy, that is fine that doesn't upset anyone, it's when you're talking about personal values, behaviours and professionalism […]
> I think so because rather than, obviously it's my opinion but it's not my exact comment [the ISP], whereas if I was to write a comment saying, 'difficulty with this that and the other' it would feel that I was personally attacking them, where that way it's still personal but it takes a little bit of the personal edge away

Some PEFs had observed the same thing with PEF01 reporting that she had heard the ISP being referred to as 'the university's statement', thus giving mentors some distance between what they needed to assess and their own words:

> P20: PEF01 (324:328)
> PEF01: it seems to… I don't know if it takes the personal out, because obviously nobody likes to fail anybody and there is still that feeling but I think it's the but I didn't actually write it, (KM it was the paper not me) yeah, the it's the university's statement […]

#### 5.3.2.2. Prompt

PEFs and ECs hold positions that encompass a broader view than their own particular clinical practice; they suggested that the ISP required borderline mentors to think about interpersonal skills, which they may not have previously done. PEF08 suggested that the ISP acted as a prompt, obliging the mentor to assess interpersonal skills:

> P30: PEF08 (89:89)
> PEF08: I think it gives them support but it also gives them a prompt, whereas they might have just kind of let things slip before, they are not able to as such here, they've got to do this assessment…

M12 agreed that although she had always raised interpersonal skills with students, the ISP provided structure and prompted assessment of a variety of issues:

> P12:M12 (180:180)
> M12: I think now I've used it [the ISP], I think it's a good idea because it does prompt you, not necessarily for attitude but for various other things as well.

KI1 further suggested that the tool called for mentors to question themselves and their thinking on students about whom they were uncertain:

KI1 (61:61)
KI1: yeah, I think so, I certainly think it would make them think about it because they would look at what's a fail and what's a pass and if they were uncertain then they would go to someone else so yeah, I think it's making them question what they're doing rather than putting a tick in the box, and because this isn't a tick in the box, you've actually got to pick the statements out, I think it does make you challenge it a bit more and question it, I mean the cluster skills, to be honest, it's quite easy to literally go down and just initial it and they can't do that with this [the ISP] which I think is really positive.

#### 5.3.2.3. Legitimises

The final mechanism relating specifically to borderline mentors is alluded to by PEF08 above. Reinforcing that interpersonal skills are a legitimate area of assessment can facilitate the chances that struggling mentors will feel able to actually assess them. This taps into a 'safety in numbers' feeling that as all mentors are required to undertake the assessment, that particular mentor is not alone. This mechanism is related to **permission** discussed in CMO1 [5.2.2.2]. M14 agreed that the ISP might support junior mentors inhibited by lack of experience or empathy with the student—having recently been students themselves— in giving critical feedback:

P14: M14 (152:156)
M14: yeah, probably, but I've seen some of the more junior mentors wouldn't, they don't feel like they should criticise people and especially if they've not long qualified themselves […] they still know what it feels…well I still know what it feels like to be criticised but have your confidence chopped down when you think you're doing alright is…
KM: so you think this might be useful for some of those mentors in that situation who need a little bit of...something to back them up
M14: yeah yeah

EC2 suggested that the ISP could direct inexperienced mentors in their assessment and reinforce that the HEI is actually interested in these comments:

P17: EC2 (179:179)
EC2: […] it gives them a guide for what sort of things we're looking at, because if you said to maybe an inexperienced mentor, how does your student lack maturity? Would they have thought of putting that before? I guess not, do they think maturity is important? Especially in the young students, can you see that they? It gives them an idea of what they're looking for in a nurse really, in a qualified nurse.

PEF08, speaking both as a PEF and from her own experience as a mentor, emphasised that it took a strong person to give critical feedback to borderline students. She suggested that merely by its presence in the documentation, the ISP could support those mentors who did not feel able to initiate discussion on their own:

P30: PEF08 (83:83)
PEF08: they love it, for the same reason I do, it's that you've always had these students

> who are borderline and you know, yes, if you are a very strong person you can do something about it but I think on the whole people aren't experienced enough, a very small percentage of mentors would actually be experienced enough and mentally strong enough to deal with it

### *5.3.3. CMO2 Outcomes*

It has been observed [see section 2.3.2.1, section 5.3.1] that borderline mentors lack confidence to assess students on interpersonal skills, informally or formally. In this configuration the mechanisms of **distance, prompt** and **legitimises** increase the outcome of mentor confidence. An ***increase in mentor confidence*** is also a mechanism in CMO1 [see Figure 14, p. 112 and section 5.2.3.1], facilitating the outcome of overtly assessing interpersonal skills.

M09 identified that she lacked the confidence (she termed 'cleverness') of her colleagues and agreed that the tool allowed her to give critical feedback that she might have otherwise not provided:

> P9: M09 (115:117)
> M09: Yes, some of my girls [referring to colleagues] are pretty tough. Yeah they will [give critical feedback]. I don't mean tough in a mean way but I would look at the positive things and I would say "this is very positive but you need to work on this" whereas some of my girls would handle it in a different way but much better than I would because they would maybe say "what does being professional mean to you?" and explore it through that way whereas I am not quite so clever at that.
> KM: Because you say that you are quite positive in a sense does that tool allow you to give a little more critical feedback than you would if you didn't have those words there?
> M09: Oh definitely I think it does yes.

Senior nurse and confident mentor M01 specifically suggested that the ISP helped mentors to develop their confidence in assessing:

> P1: M01 (64:64)
> M01: But it comes with confidence and I think that this [the ISP] does help nurses to develop their confidence because if you are saying to somebody "you appear to lack motivation" you can't just say it, you have got to drill down and find out why that might be and it will tie in with other things as well

Through suggesting to mentors that the ISP could provide objective criteria making it easier to give feedback face to face, PEF08 alluded to the mechanism of **distance**. She described using the tool to support mentors, advising them to use the tool hypothetically—even before the formative assessment—to draw the students' attention to where they were and where they were heading:

> P30: PEF08 (69:69)
> PEF08: …the other thing I particularly use this for when I get these comments about

> students in the first couple of weeks students are in practice, "I have a student here, she's pretty good however, I'm a little bit concerned about her attitude because of this, this and this" and what I always say to them is "right, get out your attitude and behavioural skills profile [ISP] and go through it with them now, because it's much easier to use this as an objective criteria and face that student and go now look, I have seen that in the last couple of weeks your attitude has not been very good with me and this way of behaving blah blah blah in two weeks time we're going to have a formative assessment and at the moment I would select this particular statement about you, so if you don't want me to be failing you in three weeks time, this is what you need to work on" and then you write and action plan based on that

Nursing and many other healthcare professions have a high turnover of clinical staff in the clinical setting (Estryn-Behar et al., 2010; Loan-Clarke et al., 2010) and thus many inexperienced staff starting at the junior nurse (band five) level:

> P17: EC2 (191:191)
> EC2: …very difficult and particularly you know some of the mentors, I know they have to have at least a year to qualify but they're still quite junior, in terms of nursing hierarchy, they may never have been in supervision, managerial roles, having to deal with difficult staff, difficult situations so they're sort of on that little ladder aren't they where they are just realising they might have dealt with a few patient complaints, they might have dealt with a few issues but really the majority of them haven't been up that managerial step or ladder, dealing with behaviour or performance, they haven't been dealing with that a lot of them

Student teaching and assessment frequently falls to those closest to practice, who may be less well placed to actually assess students on more ephemeral aspects of practical assessment such as interpersonal skills [see section 5.2.1.1]. In addition, as M04 identified, more experienced nurses at higher levels are often further away from the hands on practical setting in which student nurses work and learn:

> P4: M04 (14:14)
> M04: No I think supporting student nurses and mentoring is quite an important role that is very much underplayed as part of the registered nurse role. From what I have seen, although it is highlighted in the band five [junior staff nurse], which is a nursing band in the job description, it is actually not highlighted as an actual essential until you are a band six. By the time you have got to a band six which is a junior sister role, […], you are very often one step away from the actual hands on.

The ISP can encourage junior and borderline mentors, who take on the bulk of supporting students, to take a step back from their students and comment on interpersonal skills, it can prompt them to do so and support them by acknowledging that everyone must do this type of assessment.

### *5.3.4. Challenges to CMO2*

CMO2 focused particularly on mitigating mentor weaknesses, those 'borderline' mentors who were new in post, junior in staff or struggling to support learners in

practice. Several mechanisms (**distance**, **prompts** and **legitimises**) were identified by which the ISP might support these mentors to actually assess interpersonal skills by ultimately increasing their confidence (the outcome). As it is difficult to identify weak and struggling mentors in the documentary analysis, except by the quality of their comments and timings of the assessments this has been a difficult configuration to thoroughly challenge.

Challenging the idea that the tool provided **distance**, M07 who had recently graduated herself, said she felt uncomfortable at the thought of experiencing the assessment. Equally she worried that it might further serve to harm a students' self-confidence:

> P7: M07 (110:113)
> KM: Could you imagine…how do you think you would feel being assessed by it?
> M07: I think it is quite horrible to be honest.
> KM: What do you think would be horrible? Have the students said anything to you about it? Have they said it is horrible?
> M07: They haven't no, I think they are quite chuffed when they get something quite good when they get something higher up the scale so that is nice, it obviously boosts their confidence as well but I can imagine if you are not very confident it could knock your confidence, it could do the complete reverse. If you would get a poorly and I think if you have personality clashes with your mentors and you perhaps might have issues because I used to think they might then mark you lower.

While she stated that her students did not actually seem to mind, it seems that for her, assessment was still personal. Answering MO7s concerns, EC2 reported that her students valued the assessments and seemed proud of their achievements:

> P17: EC2 (155:155)
> KM so do you think they're angling for the higher end? [items on the ISP]
> EC2: I do. It's quite astounding really that they're waving them saying look at this one! Look what I've got on this one…
> KM: so giving them some self-esteem?
> EC2: yeah, they're very proud of when they get the higher numbers, extremely proud

She maintained that they accepted the comments even when they were on the lower end of the scale:

> P17: EC2 (173:173)
> KM: ok, so your students seem mostly to accept it?
> EC2: they like it
> KM: because they are doing well?
> EC2: and even the ones that are doing not so well…

A second mechanism is that the tool serves to **prompt** assessment of interpersonal skills. This was not borne out however, in the documents provided for analysis, as

many students had the midpoint (formative) and summative assessments on the same day or a few days apart. It is difficult to separate out why this happened from the pressures of the ward and circumstances and timing of students' placements however, organising and making time for assessments is something that might be more challenging for inexperienced mentors (Ilott & Murphy, 1997; McCarthy & Murphy, 2008). Whether from inexperience or ward pressures, the mentors did the formative and summative assessments of interpersonal skills on the same day assessed clinical skills (performance criteria) in the same way. When assessments were done simultaneously or very close together, some mentors selected the same items for both formative and summative assessments, for example:

> S030801 mod 3 [second half of first year] Formative ISP: 24p, 27g, 28g, 30g, 32g[16]
> *Mentor evidence:* Shows professional attitude in how she talks to patients and communicates with others. She highlights areas of concern to her, e.g. anything that may be seen as a risk to patients, e.g. pt [patient] needing an air mattress due to pressure sores.
>
> S030801 mod 3, Summative ISP [completed the same day as formative]: 24p, 27g, 28g, 30g, 32g
> *Mentor evidence:* as before [written by mentor]
> *Further development*: is making good progress but would benefit from more exposure to ward rounds and MDT meetings

The written comments did not particularly support the items chosen, therefore, even if S030801 did not challenge her assessment or complain to the HEI, she might not have learned much. Some mentors selected *different* items for the formative and summative, despite doing them on the same day. In this example, the comments provided were not particularly helpful or insightful, demonstrating that this may have been a borderline mentor. She selected 30, '*displays confidence*' as a formative item and then 19, '*confidence will develop with practice'* for the summative:

> S030801 mod 4 Formative ISP: 19p ,22p ,23p ,27g ,30g [17]
> Mentor evidence:
> 1) 19 Practice makes perfect
> 2) 22 able to work in whatever team, she is in
> 3) 23 self explanatory
> 4) 27 is able to identify in which field she lacks more, e.g. Admission, transfer, discharge
> 5) confident in what she is doing. [30 implied but not written next to the comment]
>
> S030801 mod 4 Summative ISP, same day as formative: 17p, 19p, 23p, 27g, 28g[18]

[16] 24 displays a mature attitude; 27 identifies own learning needs; 28 has made a useful contribution to the work of the team; 30 displays confidence; 32 offers informed and considered opinions

[17] 22 fits well into the team; 23 has a pleasant and approachable manner; 27 identifies own learning needs

> Mentor evidence:
> 17) always asking/interested in new learning opportunities
> 19) will become more confident with practice
> 23) good attitude at work and within a team
> 27) able to identify areas where she lacks knowledge
> 28) works well within a team, good team player.

Here, the mentor technically assessed interpersonal skills, but was not prompted to do so in a way that could support student learning and development.

The final mechanism in CMO2 is that the ISP **legitimises** the assessment of interpersonal skills. As with **permission** [section 5.2.4], a challenge to this mechanism was difficult to find in the interview data or in the documents themselves. The implicit challenge to this might be that those mentors who assess half-heartedly or in a less than timely manner might be doing it this way because they are reluctant to assess interpersonal skills, despite the ISP. This however, must remain conjecture. Broader assessment issues about timing of placements and busyness of wards might be indicated by the fact that clinical skills assessments are being done in a similar way (i.e. the midpoint and summative on the same day). Certainly there is evidence that not all mentors were as comfortable using it and some teaching and support should accompany the introduction of such a tool [see Discussion 7.5.1].

The expected outcome of these mechanisms is that mentor confidence is increased but this may not have always been achieved as PEF07 identified. She suggested that some mentors continued to be uncomfortable with the summative assessment and the potential to fail students using the scale:

> P29: PEF07 (133:133)
> PEF07: yeah, that is an issue because they sometimes feel that they might have actually decided on that [item of the ISP] but they look and they say 'oh no this student is in second year and I don't want to fail them', they have been honest and said 'well actually I changed my mind'

And she continued, giving a suggestion for why some mentors were uncomfortable with the pass and fail element of the ISP:

> P29: PEF07 (173:173)
> PEF07: I kind of, I don't know why they say that, it doesn't sit, I mean if they wouldn't know the outcome, they make the statements and it goes back to the university…I don't if it's the ownership of it, I didn't know that you'd fail, I just picked out the statements, if that was one of the reasons why or whether it was just a kind of maybe it was too much of a,

[18] 17 willing to try; 28 has made a useful contribution to the work of the team

maybe it hindered their judgment because it was there in front of them…?

#### 5.3.4.1. Unintended consequence of using the ISP CMO2

Weaker mentors seemed to have more trouble selecting items to reflect what they really want to say. PEF01 suggest that mentors selected items as they needed to:

P20: PEF01 (108:108)
PEF01:[…] needs more experience is also being used, particularly where they are having to fail an outcome, they are using it to back that up. […]

However, two Child field nursing faculty in the web-based survey [see Literature Review 2.4.1, (Weeley et al., 2009)] reported that mentors had unintentionally failed a student:

Child field faculty 1: On a few occasions some of the Interpersonal statements do not accurately reflect what the Mentor wishes to say. For example a Mentor scored a student as no.10 [needs more experience at this level]. Unfortunately this related as a fail for a second year and this was not intended by the mentor.
Child field faculty 2: I think the concept of Interpersonal development is excellent, however I feel there needs to be less criteria and I have found some of the criteria rather ambiguous in application. For example: 'Needs more experience at this level ' (10) was used to describe a very competent 2nd year student but constitutes a 'fail'. This was discussed with mentor and was an error although clearly they felt that this was not a negative statement.

In her second interview 11 months after the first, PEF01 also noted problems with the fail/pass category [also addressed in sections 5.5.1.2.1, 5.5.2.1.1 and 5.5.4]

P21:Pef01b (3:3)
PEF01: […] There has also been a bit of confusion with them around some of the statements meaning different things depending on the stage of the student's training. That has also caused some problems as in they have given a statement in the second year which has actually failed the student when they interpreted it as being a development thing which it would have been in the first year. There have been a couple of errors because of some of the statements having two possibilities

This is further addressed in the Discussion [section 7.8] on suggestions for changes to the ISP.

### *5.3.5. Conclusion CMO2*

This configuration specifically examined the ways in which the ISP supported borderline or weaker mentors to increase their confidence to assess interpersonal skills. The mechanisms identified were that the tool gave some **distance** between mentor and student in the close practical placement environment. It also **prompted** mentors to consider interpersonal skills whereas they might not have done so previously. Finally, it **legitimised** assessment of interpersonal skills

demonstrating to uncertain mentors that they were required to assess what might have been seen as a personal area of student performance. The challenges demonstrated that some mentors might still have felt too close to the assessment, e.g. reporting that the experience of being assessed by the ISP would feel horrible. They may also not have been sufficiently prompted, either not addressing interpersonal skills or doing so incompletely.

## 5.4. CMO3: Clinical setting variability

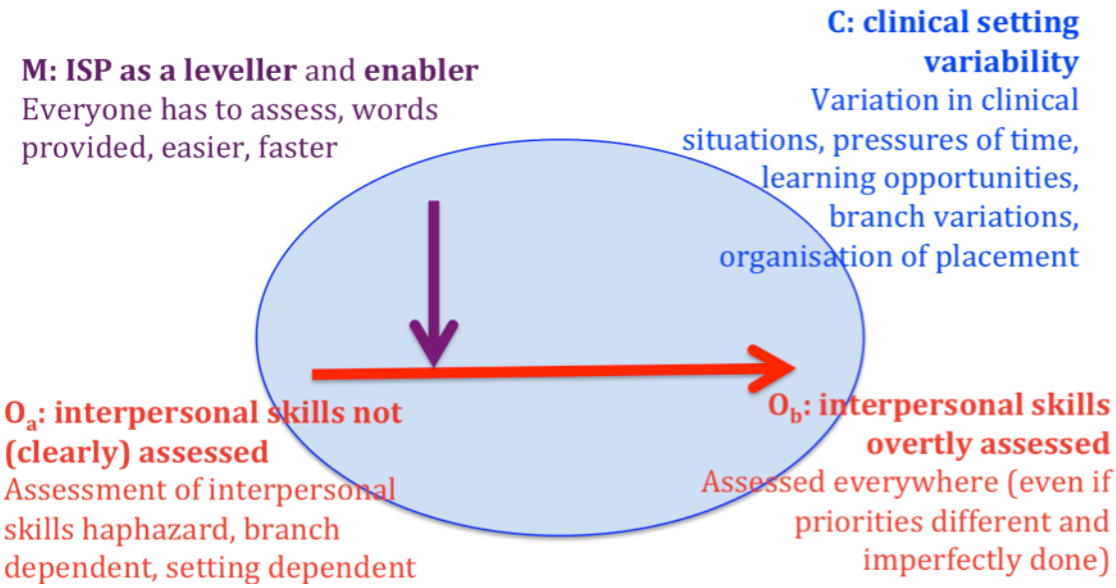



***Figure 17 CMO3 Clinical Setting Variability***

In many professions with a practical component, it is difficult to standardise the students' experiences (Ginsburg et al., 2009; Galbraith et al., 2011). In determining assessment processes, a balance must be struck between rigid 'testing' of goals that not all students may be able to achieve and a loose strategy covering any circumstance (Schwartz et al., 2009). In this study, practical placements varied in many ways; in length, timing and organisation of student experiences, the field of nursing, and types of clinical area (hospital, community, out patient, nursing home etc.) and focus (psychiatric, surgical, medical, critical care etc.). Even in similar types of clinical areas students experience placement settings which respond differently to the pressures of clinical practice, staffing levels and so on. Within this context of variability the mechanism identified was that of the ISP as a **leveller** and **enabler** of assessment. The outcome was that interpersonal skills were overtly assessed.

CMO4 also explored a variable situation, that of differences between mentors [see section 5.5.1], however findings around **levelling** as a mechanism are confined to section 5.4.2. **Levelling** in both contexts is addressed in the section 6.2.4.

### *5.4.1. CMO3 Context*

#### 5.4.1.1. Practice setting variables

In a sense, each student is engaged in his or her own nursing programme, having worked with different clients, families, staff and in a variety of settings. Additionally, each practice setting welcomes students in their own way, while expecting students to know what is wanted:

> P24: PEF03 (69:69)
> PEF03: […] the staff themselves have this idea that automatically people know what is expected of people and it's a real difficulty I'm working on at the moment, on welcome packs, to uniform those so that all students have the expectations of the areas articulated clearly beforehand, so you know where you are at, because students find different variations, they are not standardised the quality

Within those environments there are additional inconsistencies; being busy and under pressure are common complaints in many settings (Govaerts et al., 2011). In an eloquent statement, PEF07 described some of the many challenges that nursing mentors face in assessing pre-registration nursing students, and exemplifying the particular challenge for community nursing in the Adult field programme:

> P29: PEF07 (205:205)
> PEF07: I mean, sometimes because of the time frame, it is a forced relationship and the student is obviously there to learn […] they don't know the student for very long they have to make a comment or judgement, maybe not always working with the student as much as they'd like having to rely on other people's comments as well… and [community] mentors can find that difficult because they are then relying on colleagues to feedback and sometimes they're not very good at feeding back verbally or in the document and it's a huge responsibility then for the mentor because they can only go on the information that is provided to them or what they saw themselves I think people do feel uncomfortable and unless there is any major concerns really I think most of them, from a district nurse point of view, will feel as though if they haven't heard anything, well the student will pass […]

This pressure meant that mentors found it tricky to assess students after a short period of time:

> P7: M07 (75:75)
> M07: I think it is very difficult especially when they perhaps haven't been here for a long period of time and you have got to assess that. Yes but at the same time I think it is a good thing to do definitely. I think it is very helpful because obviously just because you

have…you can do certain tasks doesn't mean you have the skills that you really need.

Despite the difficulty in doing so M07 asserted that it was important to assess interpersonal skills. M08 acknowledged the variability of experience for students that can exist within one setting as she described 'busy days' and 'nice days ' and their impact on her ability to teach students:

P8: M08 (19:19)
M08: Every day it is completely different. One day it can be very busy, we don't get much time to spend with the students to teaching them or even to showing them because you are always in a hurry to do things. Like you have got loads of things but you find sometimes…like days like this today, it has been a very nice day, I managed to take one of my students with me to do her [inaudible] drugs. She came along with me, she observed me, what I was doing […] So I got lots of opportunities there, as I told you, when you are busy it is very difficult to look after the students but they are very good actually. Well they just carry on doing…they just get along with the things that they want to do.

M15 described the impact of being busy on assessment of all skills, including interpersonal skills and student self-assessments:

P15: M15 (233:233)
M15: about 50/50 really if I have the time and they haven't done it [referring to getting the student to do the self assessment before she does her assessment] then I say you do it first then I will do it, but 9 times out of 10 we're so short of time that it's their last day or second to last day and I'm trying to get their last few done and I'm like well it has to be done, I can't send them away to do it because I don't have the time after to do it with them

Participant M12 described how she dealt with students she knew were coming back to her base placement, something which the majority of Adult and Mental Health students do not experience but which may happen in Child or Learning Disability fields [see section 1.2.1]:

P12: M12 (47:47)
M12: She has picked up a lot since then and I think that you've always got that in the back of your mind with regards to…if you have a problem student, you always think "okay when she comes back…" So I think a few weeks before she came back for this term, because she's been off doing other ward placements and I sort of said "okay, we have to try and do…this, this and this" […]

However, PEF03 highlighted that sometimes mentors with students in base placements found it difficult to remember where a student should be in their progression as they spent so much time in the same setting:

P24: PEF03 (69:71)
PEF03...I picked up on this on the children's ward, where the Adult branch move every six months, people kind of know what level they [the students] are at but on the children's ward there is…it's more seamless, there is much more of a continuum because that's their core area […], the expectation [of the students' ability to fit into the ward] is higher, quicker in that area, 'the slow to settle' and all that shouldn't be a problem because you're [the student is] not going to a different area, […] [The mentor has] seen them for three

> years, […]
> KM: so you're saying that in the children's areas because they see them constantly over three years that they have a hard time sometimes distinguishing between what they'd expect from a first year, second year and third year?
> PEF03: yes

#### 5.4.1.2. Field of nursing

Mentors from Adult, Children's and Learning Disability fields of nursing volunteered to participate in the study. While no Mental Health mentors volunteered to participate, they are represented by PEFs 03, 05 and 07. These PEFs each asserted that Mental Health nurses have fewer problems assessing interpersonal skills suggesting that Mental Health mentors are more likely to comment on or speak up about interpersonal skills than Adult field mentors:

> P25: PEF03 f-up (9:9)
> PEF03: I actually did a session for a Mental Health group which is practitioners that I don't usually support and we discussed the interpersonal skills profile as part of that and their comments were very interesting in that it is an extension of their normal assessment skills and they felt very, very comfortable using it and didn't feel it was at all judgemental because they are using that as part of their professional toolkit all the time.

> PEF07: I do feel that the Mental Health nurses do really put a lot of value on interpersonal skills, I don't know if that's because in Mental Health nursing, communication and forming a relationship with your client group is so important and as a student nurse coming in that they also assess you on that, yeah I would agree with that actually, they are probably more likely to be more strict on the interpersonal because it is such a critical part of the role really

PEF03 further suggested that not only did Mental Health nurses find it easier, but nurse from other fields found assessing interpersonal skills harder:

> P25: PEF03 f-up (11:11)
> PEF03: Yes absolutely, so when we were talking about asking them [Mental Health field] to give me examples that they had observed in practice that would actually support the interpersonal skills profile, they tripped off the tongue and they didn't have any discomfort in making judgements on behaviour whereas the acute [Adult field] staff, the Child branch really struggle with it still in that they are quite happy to verbalise it but they are less comfortable putting it down on paper.

There is insufficient evidence to make claims about fields of nursing and interpersonal skills but it may be that fields of nursing which deal with interpersonal skills as part of their core clinical skills may require less support in assessing them in their students.

### *5.4.2. CMO3 Mechanisms*

#### 5.4.2.1. Leveller

Variability is a factor that is impossible to remove from students' experiences, however, through requiring all mentors to do the same assessment and provide evidence to support their choices it is possible that the ISP can provide a way to level these differences:

> P13: M13 (150:150)
> M13: yeah then you know it might be difficult, but clearly it shows and then everybody can be reading from the same song sheet and you know what's unacceptable and what's acceptable and the grey in between…

Participant M04, who was lukewarm about the introduction of the ISP, suggested that it gave mentors a standard or measure:

> P4: M04 (102:102)
> M04: […] As it stands you can see why it has come out and yes it does give you a yard stick I guess.

#### 5.4.2.2. Enabler

Various mentors, ECs and PEFs suggested the ISP made assessment of interpersonal skills quicker and easier because the mentors themselves did not have to come up with the phrases or words to describe the behaviours observed, enabling assessment to happen even in pressured and challenging circumstances:

> P16:EC1 (101:101)
> EC1: It [the ISP] makes it much easier, it makes it able to really document it so it can be seen whereas before it was just a comment in a comment box, now, well there is a scale to it as well, this person is very low numbers instead of higher numbers, it gives them [mentors] a tool…

> P22: PEF02 (127:127)
> PEF02: I think probably it's like a, it's easy isn't it, writing a learning contract you've got to have the time. The ward staff are phenomenally busy, when you've got a failing student and it's phenomenally hard, especially some of the ones we've had recently so to be able to write a number and just write a brief thing kind of gives a nice segment section to be able to do it, so yes they say they like it they find it easy they find it useful.

In a statement that also encompassed the **prompt** mechanism discussed in section 5.3.2.2, M01 described what made the ISP easier to use:

> P1: M01 (90:90)
> M01: it is almost like a prompt as well because you think you haven't got to think so hard about "what am I going to write about […]" it is all there in a summary and you are picking out the key aspects and then you are elaborating on them, I think it makes it quicker.

Not only are blank reports difficult to write, but complex and detailed assessment tools are also time consuming and can be missed out, as M05 stated:

> P05: M05 (93:93)
> M05: […] I think it is going to be harder and harder to make the time and the documentation tends to get more detailed or precise, it is not going to be done either one, as thoroughly or two, as often […],

Mentor 08 was not very supportive of the ISP's introduction and use, saying she could not see why it was particularly needed:

> P8: M08 (117:117)
> M08: I don't know, what is the purpose? Why does this [the ISP] have to exist? Why can't you just write it okay this is what have been observed, why can't we just write a general feedback? Like saying that if they can just ask okay, just say something, what do you think about a student? That includes everything. Okay she is quite confident, she is well motivated or she is proactive, you can just write like say about your student. Not to say about your student, something, have a brief explanation.

Despite her feeling that it was not necessary, she also describes the tool as being easy to use:

> P8: M08 (37:37)
> M08: Yes, picking things is quite easy like you can read and think "oh yes, she is quite good" you know that because when you read that you come to know what about the students, "okay yes she does this" or "yes she is like this and she is quite mature" you come to know.

In the challenging real work environment of clinical practice mentors, PEFs and ECs identify ways in which the ISP could minimise some of the considerable differences between them by offering a tool that all mentors, regardless of comfort level with assessment of interpersonal skills would use. Similarly, assessment of interpersonal skills is enabled by making it quicker and easier to do so. The outcome is that interpersonal skills are clearly assessed.

### *5.4.3. CMO3 Outcomes*

As in CMO1 [5.2.3] and CMO2 [5.3.3], PEFs, ECs and mentors stated that the ISP facilitated overt assessment of interpersonal skills compared to the documents that had existed previously:

> P1: M01 (53:54)
> KM: What did you do before that existed? Presumably you had students with the same lack of motivation and all that kind of stuff, how did you address that before?
> M01: You would meet with them and say to them about it. On their documents you have a bit about comments and you put summative, I'd write a spiel about you need to be more

> assertive or you need to look at prioritising, identifying and prioritising and you would have the opportunity to then review the learning contract and maybe put something in there that they needed to work towards as part of their behaviour but there wasn't ever a tool in which to measure it.

EC1 also reported that the ISP enabled the assessment of interpersonal skills:

> P16: EC1 (79:81)
> KM: And the […] ward, were they pleased that they had this ISP?
> EC1: Very much so, I think all the wards see it as a way of articulating the way the student behaves, whereas before they didn't have that.

### *5.4.4. Challenges to CMO3*

Earlier it was contended that in the variety of practical placements and their particular pressures, patient groups etc., that the ISP was a **leveller** and **enabler** allowing all mentors to assess interpersonal skills more quickly and easily. This has been challenged on several fronts.

PEF03 recounted a case where experienced mentors in the Child field setting felt unable to document problems with a student despite the existence of the tool:

> P25: PEF03 f-up (13:13)
> PEF03: Even with the numbers [the ISP], we have had an occasion in the last six months where this girl's [student] behaviour…they would not move forward from "she's odd, she's not safe" and they really had problems quantifying it, even though that tool was available, to such an extent that even when we actually had her removed from the site such was their concern about the things she had done, the audit trail was appalling and yet we had had four quite experienced mentors verbalise their concerns about this girl, and so we have actually had to go back and do some specific documentation sessions about using the documentation although these are staff who have been mentoring for considerable amounts of years they were not seeing this as advantageous.

Time is also a problem; there are some short placements of a week or two, and longer placements of four weeks also require a midpoint assessment quite early on. A new mentor [see CMO2 0], M07 struggled with this:

> P7: M07 (97:99)
> M07:[…] I mean the interpersonal skills profile, I suppose it is quite hard sometimes when students have just started and are settling in to be able to mark them along that scale really.
> KM: How much…is it because the mid-point has to come so quickly?
> M07: Yes definitely. I mean when they are out of placement and in college it just makes it really difficult and obviously I don't work every day so…to be able to assess them accurately I think is quite difficult and I think it is maybe slightly unfair sometimes.

Furthermore, the notion that specialist areas might be constrained in their use of the ISP was raised by M15 and PEF03. M15 raised one aspect saying she could not

'reward' or mark students on some of the higher descriptors as for pre-registration students her area was too specialised:

> P15: M15 (221:221)
> M15: I think it's useful in the ones that are failing or struggling to…because as you said you can use it to highlight or demonstrate where they are struggling, the ones that are really good, that as I said, because of the setting they can't,… I'm kind of marking them as a pass or a good but my instinct says they are better than that but because it's this area they are not doing informed decision making [item 34] because they can't so I'm having to mark them down.

On the other end of the scale PEF03 highlighted the risk that specialist areas may confuse lack of confidence in the specialism with lack of confidence generally:

> P24:PEF03 (121:121)
> PEF03: […] this is a girl [mentor] working in a [specialist area], 'if you had to pick five categories today about this student, what would you pick?' […] And interestingly she picked lack of confidence inhibits effective performance [tem 9, would be fail for student in 3rd year] so I said ok, […], 'is that because she's not familiar with the specialist area or is that because she's truly ineffective?' And she went, 'well she doesn't know enough about the specialism'…'but is the rest of her nursing knowledge and the rest of her skills consistent with somebody in the third year of the course?' She said 'yeah', so actually, this is about her working in the specialist area and being ineffective in the specialist area, not having enough specialist knowledge that wouldn't expect a pre-reg[istration] student to have… and I said 'if you picked that category you would be effectively failing your student who you've said is good', and at this point the mentor became completely panic stricken that she was effectively failing the student, something that she didn't actually feel reflected… and that was the difficulty for the specialty area, they couldn't actually separate what would be the expectations of somebody in the specialism and what was truly ineffectiveness….

This possibility raises questions about the limitations of use of the ISP in specialist settings [see section 6.2.2] but also demonstrates that the mentor would be articulating these points to the student who could then directly, or through the university, challenge the assumptions being made [see section student can challenge 5.5.3.1].

Touching both on CMO3 and CMO4, M14 particularly found that the tool was subject to variation depending on the placement and mentor:

> P14: M14 (117:121)
> M14: I don't really like it personally, I think it's very subjective, because as I say different people respond differently depending on which placement they're in and who the mentor is, whether they create some kind of rapport with them or not…
> KM: so the response of the student varies
> M4: yeah, I think, the way you have to tick off that list and say that pass well at that or pass excellently at this is, it's just, I don't know, I just think there could be a definitely be a better way of measuring their abilities…like, interpersonal skills, good verbal communication with the MDT and you give them a score of 1-5, 1 being pretty useless and not very animated to 5 being proactive, really autonomous, able to communicate effectively, I just think there should be some kind of scale like that rather than just the… because they're not even all the same in that list are they, they are very all over the place

> really, it's not like can do it at this level, can do it at this level, it's just like can do it or can't do it.

She suggested using a rating scale with items more specifically listed. Her proposal still supports the mechanism of **legitimising** as M14's suggestions include a way to assess interpersonal skills that would be required of all mentors. As M14 continued the interview, it became clear that her suggested tool was something she was familiar with and was based on a way she was assessed in her own training:

> P14: M14 (160:160)
> M14: […] I trained in another city and I think my practice paperwork was really quite good because it was graded like that, you got a score and you could see yourself progress over that year, and the criteria changed depending on what year you were in but you could see yourself …beginning of your first year you'd get 1s and 2 s by the end of the first year you were getting 4s and 5s so you felt like you were progressing…

M14's criticism referred particularly to able students who were already scoring higher up the scale whilst other participants suggested that less able students see that they are progressing as they go up the scale.

EC2s story of a mentor assessing a student in constrained circumstances addresses some of these concerns about unevenness (lack of levelling) in assessing interpersonal skills, demonstrating that a student can and did challenge her assessment [see also section 5.5.3.1] and the mentor responded:

> P17:EC2 (155:155)
> EC2: And in actually fact I did have a student who came to me last week to say they'd all been crossed out and signed, dated by her mentor, because when she came to have her summative she had scored her quite low and she said 'I don't believe you've scored me accurately' which is a very, challenging, which is good, so the mentor quite rightly said 'well ok what do you think you should have for this?' And she said 'well I think this and that' and the mentor quite rightly said 'well can you tell me why? Can you recall an event?' And of course the student could, and she said 'yes actually I remember a time when 'dedadeda' and you told me that I had great initiative' etc. so the mentor crossed out all of her first rating score and signed and dated it and increased the student's….
> KM: and did her comments reflect that as well?
> EC2: yes she did and she said 'maybe I was rushed and I didn't take the time', but the student was quite concerned because it's very important for the student to get the higher end….

Finally, although participants described the tool as being quicker and easier, in a follow-up interview PEF03 raised the point that mentors might want something even simpler:

> P25: PEF03 f-up (59:59)
> PEF03: […]I think now people are saying 'oh bloody hell there are thirty five of them that I

> need to wade through' or whatever. Whereas if they are a good student, I know if they are a good student I just want to go 'yeah, they're good. They're good, they're competent, they're engaged' or 'no, they're not good, they're not competent, they're not engaged and this is why'.

This point—though challenging the notion of a quicker, simpler tool—may provide evidence for raised awareness [section 6.1]. As mentors become used to assessing interpersonal skills, they begin to take on more responsibility for assessing interpersonal skills themselves, making the detail of the tool somewhat superfluous.

As discussed for CMO2 [see section on challenges 5.3.4 and unintended consequences 5.3.4.1] some mentors may require more teaching, explanation or support in using the tool.

#### 5.4.4.1. Unintended consequence of the ISP CMO3

No specific unintended consequences beyond the limitations discussed above [for specialist areas or the time pressures in short placements see section 5.3.4] were found for this configuration.

### *5.4.5. Conclusion CMO3*

Students on courses with practical or clinical components necessarily encounter a wide variation in experiences (Hafferty & Hafler, 2011). The ISP introduces a way to level that variation by providing a standard assessment that is less arduous and time consuming. It is not an ideal tool for some particular specialist settings or in areas where there is less time to get to know the student (and as discussed in the section 5.3.1 some weaker mentors), however, for many participants it supports the overt assessment of interpersonal skills.

## 5.5. CMO4: Variability of mentors' experience and students' expectations

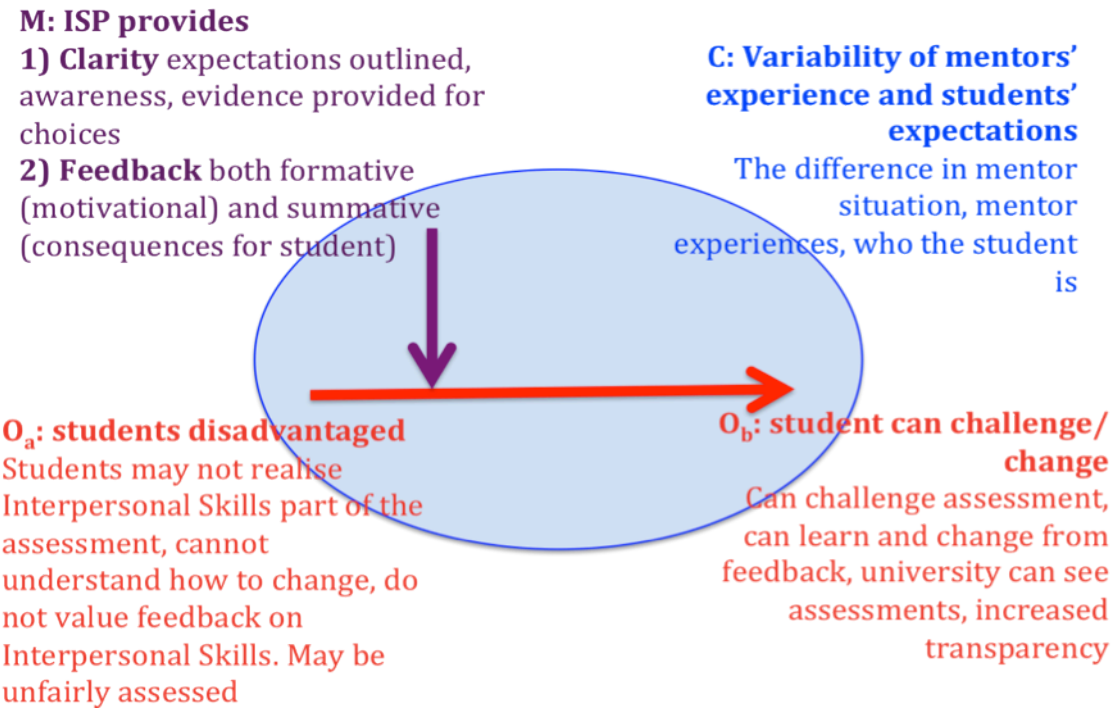



***Figure 18 CMO4 Variability of mentors' experience and students' expectations***

The ISP can be a focus for providing **clarity** around what mentors are expecting and facilitate the giving of **feedback** for how students experience assessment. As in CMO3, this configuration focuses on variation. In the variety of combinations of mentors and students there are also risks of clashes and unfairness. The mechanism of **levelling** has been explored in CMO3 [see section 5.4.2] and is not repeated here. Some participants raised the idea of 'unfairness' in interpersonal skills assessment [section 5.4.4 p. 146, 5.5.1.1], however, here the mechanisms focus on levelling more specifically through **clarity** (and providing **evidence** for selections) and **feedback** with overt **consequences for the student** [addressed in section 5.2.2.4].

### *5.5.1. CMO4 Context*

#### 5.5.1.1. The difference in mentor situation

Mentors represent the complex whole of nurses in general and are drawn from recent diplomats or graduates to those practising for 20 years or more. Nursing education and practice has changed over this time (Hyatt et al., 2008) and mentors' expectations may vary accordingly. PEF01 put it pithily:

> P20: PEF01(200:200)
> PEF01: […] the potential is that this mentor would have ignored it, that mentor wouldn't. And you've still got the difference in mentor situation, which we've tried very hard to improve and I think we've achieved it to a certain extent, but you're always going to get some…

PEF03 also identified the range of expectations, especially around what constitutes professionalism:

> P25: PEF03 f-up (39:39)
> PEF03: […] there is a sort of a continuum of ideas about what constitutes unprofessional behaviour, and it actually seems to be related to when people trained. […] So nursing has gone through such a cultural shift and quite, you know, over only a thirty five year period but we have got mentors who will have trained anywhere from '79 their own culture but people have trained in the last five years, people's expectations are really different. You are asking people to make a judgement against something that is very different.

Mentors' expectations can be shaped by their own training and assessment (Hodges et al., 2011); in this study mentors reported a variety of experiences. Some mentors began their own training with previous healthcare experience and valued their knowledge when they started. Others came in directly from sixth-form college (secondary education) or from other career or life choices and valued their fresh perspectives. Several participants had trained outside of the UK and perceived their own training to be more rigorous that that of their students.

The ISP assesses the student's level of confidence in the practice setting (items 9, 18 and 30[19]), which might be influenced by familiarity with the physical setting of a ward or medical terminology. M04 suggested that the reality of the clinical experience might come as a shock to those without previous experience:

> P4: M04 (4:4)
> M04: […] I came into nursing via the NVQ [national vocational qualification] route and trained slightly older than straight from sixth form which gave me a completely different

[19] 9 lack of confidence inhibits effective performance; 18 has developed in confidence; 30 displays confidence

> perspective and I am curious as to how students that come in directly from education find it. I think it is a bit of a culture shock to be honest, from experience…

However, M05's comments reflect the subtle drawback to having had previous experience:

> P5: M05 (129:129)
> M05: I was lucky because I had worked as a healthcare assistant before I did my training so with the basics I was all right with all of that and I had done enough clinical work. I wasn't above my station and that I knew everything but I was keen to learn. The thing that I felt was a shame was that if someone had taken the time to teach me I could have probably helped them out a lot more on their shift.

By saying she was not 'above her station' she acknowledged the hierarchy in the practice setting and the student's place at the bottom. She implied that she took care to demonstrate her understanding of these subtleties through her attitude as a student.

M14 points out that many mentors have trained not just within the UK system but have experience only within a particular hospital setting:

> P14: M14 (160:160)
> M14: I think it also depends because a lot of the people who work on our ward have all been trained within the trust, so they've never ever known anything different, but I trained in another city and I think my practice paperwork was really quite good… I've worked in four trusts in total and I've seen a variety of different ways of doing things

This variability frames the expectations of mentors for their students and forms part of the context for assessment of interpersonal skills. PEF03 went on to suggest that this variation could potentially be unfair to the student, where mentors in a practice setting have different ideas than the student making it difficult for the student to get a fair assessment, especially on interpersonal skills:

> P25: PEF03 F-up (35:35)
> PEF 03: Yes and the thing is it is very difficult because obviously it is more cultural I think, it has a lot to play in what the students behaviour and attitude will be in practice and if the students are astute and can work out the culture of a particular environment and play to the strengths of that culture they will be successful and they will be judged favourably on that, but if they are very questioning or if they are […] It is almost, not their behaviour, but the way they phrase the way they talk, their body language, even the way they are at coffee breaks will all contribute to that and I guess…looking at this and working through these problems over the last six months I didn't realise how much playing the game was important and I think you know, if students are having a problem now they are not going to go to their mentors because they are going to be judged on them.

However PEF02 suggested that any assessment process was open to charges of unfairness:

P22: PEF02 (178:178)
PEF02: even if [the ISP] wasn't there, we went back to the old system, like learning contracts that we're so used to, that could still be discriminatory, doesn't have to be just this particular tool, it could just be you don't like me whatever the document [is], it's a load of rubbish. It could be anything.

When looking at the mechanisms and outcomes it may be that the ISP increases transparency so that students can challenge assessment, possibly mitigating the risk of unfairness [See section 5.5.3.1].

#### 5.5.1.1.1. 'I would have dragged myself in'

Mentors, PEFs and ECs all mention differences in the expectations of students today from their own experiences. M15 identified a different work ethic stating she would almost never have called in sick:

P15: M15 (141:141)
M15: oh my god no…I would have dragged myself in [reference to calling in sick], and if the ward was busy I would stay late to help them out and I used to bend over backwards to get the most out of what I could…

EC2 pointed out that certain clinical skills were prioritised in the past and that students now did not always have the same opportunities to achieve them:

P17: EC2 (45:45)
EC2: […] the mentor who had been qualified for many years, I guess like a lot of us, our expectations are different, you know, maybe 15, 20 years ago, you know you always hear you know the older nurses say, oh we were running a ward and we were, you know we'd done 52 catheterisations, we'd done all this and we'd done all that and [the mentor's] expectations were that the student should have done this particular thing, now it was coming to a mutual agreement, which we did, that the student hadn't been able to gain those skills in the areas where she'd been, […], but she hadn't had the opportunities

PEF03 takes this farther in making a link between the change in status of students from part of the workforce to part of the HEI, suggesting that students now felt less connected to placements and thus prior to the introduction of the ISP, the consequences of a reprimand or discussion around behaviours and attitudes carried less weight:

P24: PEF03 (49:49)
PEF03: I think the biggest feedback I get from staff is that when students were part of the workforce, students automatically behaved because they actually saw a direct consequence of their actions, when I was a student I was a student of that hospital, if somebody reprimanded me we knew that had a direct bearing on my reference and everything else. Students tend to behave now like they're a university student and they're doing you a favour by turning up […] not all of them but some of them the shifting balance means that they don't have as much reference if you like, to the trust experience as some generations of mentors, so when mentors meet a problem, they say, 'I can't understand it, why when I've spoken to her about time keeping she doesn't amend her behaviour' or 'I can't understand when I challenge her about her uniform she seems to think it was

acceptable.'

PEF02 suggested that what was acceptable became known to students over time on the programme:

P22: PEF02 (166:166)
PEF02: …last time at the induction [in the early part of first year] I had complaints from the academic building we used on the attitude of these individuals, it was appalling. But, the same week I had the third year students in, completely different. Almost like there had been an…institutionalised. They were polite and friendly, they weren't all trying to go home at a time, no one asked me if they could go early, they knew what the rules were.

#### 5.5.1.2. Who the student is

Students also come into the programme with varied histories and experiences. Over the course of the programme, it is expected that students will develop and improve all their skills, including the interpersonal.

##### 5.5.1.2.1. Progression through the programme

Students enrol in a three-year programme [see section 1.2] and begin placement experiences after approximately six weeks in the HEI. The ISP requires mentors to score some items differently for students in the first year of the programme compared to the last two years [see p. 55 and Appendix A, p. 255 for further detail]. This presented some confusion for some mentors as these 'borderline' items are marked F/P or P/G etc. [see 5.3.4.1]. However, the opportunity to make a distinction between expected achievement in the first and final two years was also seen by others, even by M04 who was doubtful about grading, as an important reflection of the idea that students should progress—including in their interpersonal skills—over time:

P4: M04 (110:114)
M04: …but I'm not convinced about the pass, fail and which bits you have to pick.
KM: So you don't like the fact that it is graded?
M04: No, but then…you could say it is a judgement call isn't it?
KM: I am interested in that, what is it about the fact that it is graded that is less appealing?
M04: I don't know. It's one of those strange things, I look at it and…I think it probably is that you have got this borderline on all of them, it's unclear, it's almost murky but then I suppose dependant on where they are in their training it is going to reflect on how they are going to manage.

M10 saw the change in grading in different years as an explicitly positive part of the tool:

P10: M10 (122:125)
KM: What do you think of the fact that you can pass or fail it in different year?
M10: I think that's useful actually because it gives you as a mentor a guideline of what they are looking for as well.
KM: And do you think that is fair enough that they should be passing in the first year with some things and failing later because I've heard some suggest that it is a bit harsh, or are you okay with that?
M10: Well they need to improve don't they? So what is acceptable at year one from interpersonal or a clinical skills point of view is not necessarily acceptable at year two, they need to progress. They do need a progression on it.

In this section the borderline category of items has been presented as a context that students progress through the programme. That there is some doubt about the clarity of the categories for some assessors [see 5.3.4.1] can be construed as a challenge to this configuration, however, it is also part of the mechanism of **clarity** itself that students are made aware [section 5.5.2.1.1] that what is acceptable in year one is not necessarily acceptable in year two.

#### 5.5.1.2.2. Borderline students

Configuration CMO2 called 'mitigating mentor weaknesses', focused on borderline mentors [section 5.3.1], however, participants also discussed borderline students. KI1 described students who were not failing, but who struggled to achieve a clear pass, as those who 'bumbled along' and presented a challenge to mentors:

P31: KI1 (17:17)
KI1: And it's the ones that you think ooh (groan) on a good day maybe they're ok and then on a bad day maybe they're not so ok? I think they're the ones that drift, the ones, you couldn't say they were unsafe as such, but you know if you were lying in the hospital bed they wouldn't be the first choice of a person you'd want looking after you. And that's the ones I think the mentors struggle with, the ones that are really bad are very few and far between, everybody sees what needs to be done and it is done. I don't think we have students who get through who are clearly unsafe and inappropriate but I think it's the ones that are, that 40% it would be in theory, 39%, 40%, 41% [40% is the pass mark for theory] and I think they're the ones the mentors don't know what to do with and often they do bumble along, I don't think there are huge amounts of them but…
KM: it was a comment that did come up?
KI1: yeah. I think so, it's those ones who are sort of right in the middle and you don't know quite what to do so the mentors often do nothing.

From the perspective of academic support KI2 also identified struggling students and the wider issues that affect them:

P32: KI2 (20:20)
KI2: […] some of these students will then, they don't just fail practice, they'll have either personal issues or be failing assignments and will just be generally be struggling a bit, struggling a bit academically […] so it's not a huge surprise when something goes wrong in practice

#### 5.5.1.2.3. Student preparation

Some participants noted that students had variable levels of understanding of the assessment process and paperwork surrounding them, which also affected their behaviours and attitudes in practice:

> P1: M01 (16:16)
> M01: When I meet with the students initially and we go through the induction process and we look at what learning objectives they can achieve, I go through and say to them "do you understand the books?" Because it is surprising the amount who come and don't really understand, I mean the students, what they are supposed to do.

How the mentor perceives the student and their commitment to the placement can also impact upon how the mentor works with and assesses the student (Ginsburg et al., 2010). If the mentor felt the student was not that interested in being there, she may not have supported them as effectively as an enthusiastic student:

> P15: M15 (145:145)
> M15: what it feels like is, this is a very judgemental thing to say (KM: go on) it feels like the students are arriving at us going you give me everything, you teach me, you tell me what I need to know and I will sit here and take it and be along for the ride where when they get here we're like, now it's you to do the hard work, you need to go and look that up or find out about that, we will help you and we will give you the seed but you need to grow it, […]

The ISP has items relating to defining own learning needs and motivation providing a place for mentors to comment on this perceived lack of interest. This is new as neither previous institution making up the current HEI [see section 1.3.1] included a question about students' motivation or a place to document it [see also Appendix B].

### *5.5.2. CMO4 Mechanisms*

The ISP can facilitate the accommodation of variability of mentors and students with their various expectations and experiences. As mentioned in CMO3 [see section 5.4.2] **levelling** is not further explored, rather two more focused mechanisms are identified; **Clarity**, where expectations are outlined and opinions are **evidenced** and **feedback** with formative (motivational) and summative (**with consequences**) feedback being explicitly given to students.

#### 5.5.2.1. Clarity

The tool clarifies and makes explicit interpersonal skills assessment in several ways, two of which are related to this CMO configuration; by raising student awareness of the assessment, and by requiring **evidence** to support the selections made. The outcome, interpersonal skills are overtly assessed, identified in CMO1 [5.2.3.2] and CMO3 [5.4.3] also acts to clarify what is expected and how they are being assessed for students.

##### 5.5.2.1.1. Student awareness

An important way in which the ISP might work is that students are made aware of what is expected of them. M01 suggested that because students need to achieve they become more aware of their interpersonal skills [see Discussion 7.4]:

> P1: M01 (58:58)
> M01: Actually this tool can be used in a way to reflect [interpersonal skills] and because it is in black and white students are more likely to accept it I guess and be aware of it. You are going through it and because they need to achieve this it makes them more aware. Do you know what I mean?

M13 suggested that seeing what they could improve upon helped students to develop:

> P13: M13 (182:182)
> M13: yeah…it makes it easier for the student as well because they can see what things they need to improve on

M05 recounted a case where the ISP had not yet been introduced but where it could have been helpful for the mentor and student:

> P5: M05 (79:79)
> M05: I think it's good when you can sit down and say "well..." what am I trying to say? I think it is useful because of this section here going down so they can look at it and see what they need to achieve, where they need to get and I suppose in the case of my challenging student I should say really, I think it would have been helpful if she could have seen where she was at.

ECs and PEFs agreed and suggested that student awareness improved student performance:

> P18: EC3 (154:154)
> EC3: I think the students, when these tools changed, they seemed to up their game a little bit more, they're more aware of what their requirements are

And knowing that mentors using the same tools were assessing them, gave the assessment of interpersonal skills more weight:

> P29: PEF07 (137:145)
> PEF07: […] and I think maybe because the student is aware of the actual grid and what's in there, the student needs to prove otherwise then really because they know that the mentor is assessing against those things
> […]
> PEF07: whereas now all mentors are using the same tool, the same grid whereas before it was very woolly, very generic, you could read from it what you wanted, and perhaps not every mentor was as explicit in using [the previous] tool, and that actual tool is statement after statement give it a lot more clout to the mentors to say this is you because of x, y and z

As discussed above [section 5.5.1.2.1], the borderline items (those that are a pass in first year and fail in years two and three) can also alert students to their level of progress. For instance, in assessing a student M04 felt it signalled to the student that she had time to develop in first year but that there must also be a progression in order to succeed in second year:

> P4: M04 (46:46)
> M04: No because it is her first year and plus the fact, this is a formative. […] she needs to be more assertive but that is more to do with confidence and finding her feet still. At that point there was no way I would have seen her as a fail, it was more of a case of this is a very inexperienced, very young student who needs a lot, who does need more support. Okay this early on that is not going to be a fail but if it is still the same...then you would have issues.

#### 5.5.2.1.2. Evidence for choices

The subjective and ephemeral nature of interpersonal skills assessment has been addressed in section 5.2.1.1, and forms a background to the importance of providing **evidence** to support item selections, which forms part of the mechanism of **clarity** in this configuration.

M07 was doubtful about the experience of being assessed by the ISP as a person who did not see herself as confident, however, she suggested that using the **evidence** would make that feedback more constructive:

> P 7: M07 (99:101)
> M07: I know that personally I might not be that confident to start off with so I might score really low on something like that.
> KM: If you were going to score someone low on confidence for instance but you thought as the mentor that it was partially because of the timing, how would you incorporate that into your feedback?
> M07: Obviously use the part where you can write about evidence and the notes, I would put that something with time that they would be able to develop.

Other mentors emphasised the role of **evidence** in supporting their assessment of interpersonal skills:

> P4: M04 (142:146)
> M04: Yes, that's the only thing. I don't know how you would, if you were working with someone you are going to form some opinions and get to know them.
> KM: The fact that you have to evidence what you say, does that reassure you to some degree?
> M04: I think so because it means that…I suppose it is justifying the assessment. You can say "well I have got evidence that they have done this, I know they've done that and I haven't just pulled it out of the air."

Two ECs also discussed the importance of providing **evidence** as a way of taking the tool beyond a tick list or simple way of defining students:

> P18: EC3 (104:104)
> EC3: […] it gives you an opportunity to discuss and with the student all the way through, maybe in some ways it could be too prescriptive but then you've got commentary [place to provide evidence] for that element, …

> P19: EC4 (49:49)
> EC4: […] and I think what's good about it is we're not just asking them to be assessed and we're not just asking them to pick 5 things, we're asking the mentors to say, for the evidence in why they picked those 5 things, so it's not good enough to say oh you always turn up late, you don't seem to care, you've been very slow to settle, it's about giving examples, so why perhaps they've been slow to settle, why we're thinking this, why, or this is how you come across to others and this is why we think it so I think it's much more constructive to the students, […]

However, the items chosen were not always well **evidenced**. M08 reported that for her, there was not enough space in which to write and that she was uncertain as to what constituted evidence:

> P8: M08 (33:35)
> M08: That is fine to write the evidence, this is quite good but when you are writing the evidence I find that I can try…
> KM: You find that kind of tricky?
> M08: Yes. If it is quite clearly understood okay, just mention about like what do you think about her? Otherwise because you write this and you need to relate that one. You are not going to write, say for example you are not going to pick only one point and write it, you are going to need to write five different things, so it is quite difficult. When you write you have to choose your five points right and in that small space just to write everything, it is quite confusing.

Further critique of **evidence** provided is examined in section 5.5.4.

#### 5.5.2.2. Feedback

Being able to provide feedback for praise and for development was another mechanism identified in this configuration. Mentors mentioned that the ISP was not only useful for borderline students who could see the **consequences** of a poor

assessment [section 5.2.2.4] but it could also provide motivation praise for higher-level performances:

> P5: M05 (79:79)
> M05: Actually as a progressive thing as well, if someone sees that they are improving and going up the scale that is more motivational. So it can be more motivational as well.

> P10: M10 (79:81)
> M10: It's really useful actually because I think [the ISP] is assessing something, because [for clinical skills] you can tick the boxes, can they do a blood pressure, tick, can they sort out feeds, tick, but I think it [the ISP] sort of is a different aspect to them. I find that's really useful, especially when…a few of them we have had almost working above and beyond what you would expect of a second year student so you can sort of explain that with those interpersonal skills rather than just what they have to achieve.
> KM: Right and how do they respond to that?
> M10: I think they quite like it, I think they like getting positive feedback and hearing that we're pleased with them is always good

However, where critical comments are necessary, EC3 suggested that the feedback could prompt reflection on the part of the student:

> P18: EC3 (82:82)
> EC3: there is better demarcation on what, where they are, the student is more aware of it and the student can reflect back on these as well and think, well, I got this on that one and that on that one

M01 was particularly enthusiastic about using the ISP for developmental purposes both to motivate and to reward:

> P1: M01 (60:60)
> M01: You have got something that you can talk to them about and drill down. Sometimes it could just be that they are under a lot of stress; there could be underlying issues, which as a manager I have to manage within my workforce anyway […] We're all human; we all suffer from stress or hormones, whatever it may be. Then you might have somebody who is really willing to try [item 17] and has developed in confidence [item 18] after being, a lacking self-awareness [item 7] so it is really good. Because it is on bit of a scale when I am giving feedback I can say "you were here and now you are here, well done" and it spurs people on.
> KM: So you find it a very formative tool.
> M01: Absolutely whereas before it was very much pass, fail, tick all the boxes, but actually this enables mentors to give much better feedback I think.

As discussed further in section 5.5.4 on challenging the configuration, some mentors seemed unclear about the grading aspect of the ISP, both to fail and to reward. M12, who was also concerned that student could perceive anything less than 'excellent' to be a criticism initially suggested that she would not give a good or excellent to first year but then acknowledged that she had actually chosen items in that range for her stronger performing student:

P12: M12 (107:113)
M12: […] maybe it's just me but I don't think you should be getting excellents until maybe the end of the second year, third year. I don't know if it's just the novice to expert type thing really.
KM: Have you ever had a student who seemed to be doing excellently for a first year? Do you see what I mean?
M12: My other first year.
KM: Are you giving her higher ones?
M12: She's got goods at the moment, she's sort of got a couple of G's and E's at the moment.
KM: So you are reflecting that you see she is working at a higher level.

M14 and PEF02 suggested that some of the less well defined items and descriptors of the ISP should remain unclear as they could be used to protect poorer performing students from hearing too much critical feedback and being overwhelmed:

P14: M14 (125:133)
M14: yeah, the only benefit of them are, if you have got a poor achieving student, that you can pick things that are very, sort of woolly and just put them down for things like that rather than make them feel too bad you're still giving some positive feedback
KM: so are you saying you can pick some of the more serious ones to point out a problem but then you can pick out some woolly more positive ones?
M14: yeah, just to make them feel like they're not absolutely pathetic…
KM: do you think that works? Do you think a student would understand that you're giving them some critique but they still…do you think it gives you some space then so you can tell them you've got some problems [M14: yeah] but this is ok?
M14: yeah, critical positive…constructive feedback is what they say

P22: PEF02 (186:186)
PEF02: yes, definitely. Slow to settle is quite a good one because it is nice and woolly, don't change it, it's quite a good one, useful, people use that quite a bit

The documentary analysis [section 3.8.2] provides some support for the notion that mentors use the ISP to provide constructive feedback about borderline behaviours, to let students know what must improve in order to progress through to the next level of the programme. For instance S090711's formative assessment in session 1 [modules 1 and 2, see Appendix B for programme information] identified what the student needed to do and let her know that standing back was getting in the way of her progression. The mentor selected 9, 14, 17, 19, 20[20] (all passes in the first year, but 9 (*lack of confidence inhibits effective performance*) is a borderline item, and would fail in years two and three) and allowing the student to see that she was not unremittingly awful wrote:

MENTOR: […] thus admit that at this point she still has not developed confidence which makes her stand back rather than involve herself. Encouraged to be more proactive i.e.

[20] 14 needs to be more assertive; 17 willing to try; 19 skills will develop with practice; 20 assimilates new information

> communicate more with the residents. What is positive though with her is that she's enthusiastic to learn

The student herself wrote:

> STUDENT: I feel that I do lack confidence but I am working hard to address this and to actively participate in areas where my confidence is lacking. I am constantly reflecting on my abilities and feel that I am beginning to overcome the confidence problems which I had. I have learned an awful lot so far in this placement and feel that I am able to put the skills learned to good use.

Her summative assessment showed marked improvement, 18,19,20,21,22[21] (all passes in the first year) with the mentor writing:

> She is now more confident with the tasks that are given to her, she has developed her assertiveness in a way that she can say if she needs to.

Selecting items 21, indicating that she '*accepts appropriate responsibility*' and 22, that with increased participation she '*fits well into the team*'.

Feedback is a separate mechanism to clarity but M08's example of how she would give feedback to a student demonstrated that perhaps the ISP can also help clarify the feedback given. This participant reported feeling confident to comment on students' interpersonal skills prior to the ISP's introduction and stated that the tool was unnecessary [see comment p. 144]. However, reading what M08 stated she would say, it is uncertain that a student would have been able to discern what areas needed to be developed. In the text below I have underlined what I have understood to be the critical points that the student would need to take on board: P8: M08 (78:79)

> KM: So how did you give them the feedback?
> M08: Well basically I told them "do you realise, I know you are a very good nurse, you still can do lots of things and still need a little bit of development because nursing, as you know, it is very difficult, it is not that easy doing nursing, you're going to look after the patient and you are going to deal with the life and the death and it is a huge responsibility as a nurse okay", so that is the reason I will tell them "you are a very good nurse, you can definitely be a very good nurse, at the moment you are doing this many things which is very good but we all need development at some stage because we all have to improve. So if we show a little bit of interest, […] it will be easy for you an easy for me so that we don't waste much time and you don't need to come back and do lots of time [...]"

Likewise, looking at how the ISP is used in the documentary analysis it is apparent that feedback through the ISP can also be far from clear [further discussed in section 5.5.4]. For example, S090712 had been assessed very positively (including items in the 30s which are classed as excellent in first year) and self-confidence

[21] 18 has developed in confidence

was only mentioned in the 'to be developed' section of the module 3 summative assessment. However, in the formative assessment of module 4, (in the same placement and with the same mentor) she received two borderline items 8 and 9 (still passes in year one). Item 8 indicating that she '*needs to take responsibility appropriate for this level*' and 9 that '*lack of confidence inhibits effective performance*'. However item 21, '*accepts appropriate responsibility'* was also selected. What was the student to make of this assessment? Despite this confusing selection of items, the written comments indicated that the mentor believed the student had the potential to change and progress:

> MENTOR: She needs to believe she has the ability to become a confident and competent nurse. Just having a try is better than standing back and watching though sometime it can be better to stand back and assimilate information. Is conscientious and listens as well as asking questions a good quality in a nurse

But what guidance for the student was provided by this contradiction? Additionally if she '*fits into the team*' (22) and '*shows a mature understanding*' (35) in what way was she not accepting responsibility? The summative assessment two weeks later was higher (items selected pass: 18, 19, 20; good: 26 and 29[22]) with the comments suggesting that confidence had been addressed. However, the mentor's comments still did not mention responsibility, either to critique or praise the student's practice. The difference between this written feedback and the verbal example from M08 (p. 161) is that student S090712 could have asked clarifying questions or challenged the written feedback [section 5.5.3.1].

When supporting mentors and teaching them how to use the ISP, PEF08 emphasised the formative aspect of the tool:

> P30: PEF08 (71:71)
> PEF08: I've have been encouraged to see [formative use of the ISP], because as I said it is very difficult to be completely objective about students and to be transparently objective, you know you might have been objective but the students still see that as being subjective and that you're picking on them, students always blame mentors for whatever goes wrong, I've learnt that in life so I think with this, now you can pick up problems early on and say look, I think at the moment you're not behaving in a very professional way because of this, this and this, this is what I've got to assess you on and in order to meet this requirement this is what I want you to do and you can write out your action plan and the student nurse will know what is expected of them. You can review it and review it a few weeks later and say actually this is the way you were a few weeks ago when we had our conversation, this is where I put you at now, there is still some work to be done but you are edging towards a pass and keep up the good work and it's encouraging to the

[22] 18 has developed in confidence; 19 skills will develop with practice; 20 assimilates new information; 26 is able to reflect on outcomes; 29 shows a good understanding of the concepts of nursing

student as well…

KI2 and some PEFs identified some of the drawbacks [further explored in section 5.5.4] of giving feedback using the ISP, however, it seems they were more related to the sensitive nature of commenting on interpersonal skills rather than the ISP in particular:

P32: KI2 (20:20)
KI2: … if you are relatively bright and can read between the lines you can see that it is relatively damming but…
KM: damming with faint praise?
KI2: yeah exactly you can see well, you can tell from the comments that but the student doesn't see that
KM: they take it at face value
KI2: yeah they totally take it at face value as opposed to thinking well what are they actually saying here? And that can be an issue, I don't know a way around that, because unless you tell mentors to be brutal in what they write like Simon Cowell[23], then you're not going to get that type of feedback, some will, some will be harsh or the students will see them as harsh but in fact they're being very fair.

### *5.5.3. CMO4 Outcomes*

The two-part outcome identified in this configuration [see Figure 18, p. 149] is that students can challenge their assessment and that they can change their interpersonal skills.

#### 5.5.3.1. The student can challenge

Even with the ISP raising awareness of what is being assessed and the requirement for mentors to evidence and back up their choices, it is clear that any assessment of students' interpersonal skills poses a risk of bias or unfairness (Hand, 2006; Eva et al., 2011). However, in the ISP, because the assessment is documented and clearly written, one of the outcomes is that the student could challenge the assessment. Most mentors reported they had never been challenged, however, the potential for the student to be able to do so is there:

P 4: M04 (142:146)
KM: Has a student ever, if you have given them example, has a student ever said well, 'that's not what I'...
M04: No they haven't, in fairness no and I have always said 'if there is anything you don't agree with or are not sure of ask me' I do qualify what I've said, so I don't assume that it is written in stone because all I would do is write down that the student hadn't agreed necessarily with this and yes I could see where they're coming from.

[23] A harsh critic on reality TV talent shows who can be quite scathing

M13 described how a student disagreed with her assessment, but did not confront her directly, rather wrote it in the student assessment on the ISP:

P13: M13 (194:198)
M13: I asked her [to do self assessment before the final assessment] twice and she kept forgetting her book and not bringing it in, then she brought it in she hadn't done it and said well I'm not going my bit until you do yours and then she brought it in again and then she said 'it needs to be handed in' I said, 'oh ok' so I did my bit under duress and then she must have gone off and done her bit but…when I got the book back, the second time, because they give you the old assessment book and the new one and she'd written things like, 'I don't agree with…' so it was sort of a very passive thing, rather than telling me, I don't agree with that, she'd write it
KM: ok, so she wrote down in her comments that she didn't agree with you but she never told you that [M13: no] and the tutor never got in touch with you based on that?
M13: no…and I think she would've been mortified if she thinks that I'd have seen it

Despite the fact that in this case the mentor was not directly challenged, the student could have taken up her disagreement via her personal tutor or someone at the HEI [Discussion 7.6.1].

EC3 and KI1 related experiences where the assessment *was* challenged, and resolved in the students' favour, in both cases through tripartite assessment with the mentor, student and someone from the HEI. These examples demonstrate that the ISP can be a learning tool for both student and mentor [see Discussion 7.7]:

P18: EC3 (142:142)
KM …and in that case they think it was that the mentor didn't understand the student's communication, so the student wasn't necessarily aggressive but perceived of as aggressive [referring to story of cultural gap between student and mentor]?
EC3: yes, and that's what happened, the colleague [from the HEI] went out and had a three way with the mentor and the other staff hadn't perceived that at all from this student, but this particular staff member, who was unfortunately her mentor, […]
there was absolutely no problem at all with this student anytime and then right at the very end this has happened, this has kicked off, so [now] it's all sorted

P31: KI1 (33:36)
KI1: I did have one student actually who'd been marked down as a fail on her formative on her interpersonal skills and that got really messy […] and I ended up going in and intervening and actually sitting down and managing the summative assessment for them because they'd reached a point where they couldn't do it together and then ultimately the student did pass it but it was quite interesting to see, I guess it's an example of how it wasn't used effectively and actually it caused more trouble then because then it did get very personal and heated
KM: and do you think that's partially because the mentor didn't have the skills to give the feedback but also the student wasn't willing to accept the criticism
KI1: both, the student…and I think they just got off on the wrong foot but the student was then on the defensive, what was quite interesting was that it was a recently qualified mentor […] it made all three of us stop and think about actually and at the end of it, it was successful, the student passed and they sort of kissed and made up and everybody felt that they'd learned something really valuable from it […]

> KM: that's really interesting so that's a case where it didn't really help
> KI1: well it depends which way you look at it, if it hadn't have been there, I mean at the end of the day that student learnt a lot about herself, the mentor learnt a lot about herself as well, the mentor will have been a better mentor from that experience, the student then went on and did really well in her next placement, I think they gained from it.

From the documentary analysis [section 3.8.2], S030802 and S030801 also provided examples of disagreeing with their mentors' assessments. S030802 contradicted his mentor's interpretation of his behaviour. The mentor commented that the S030802 needed to develop in confidence and assertiveness in giving personal care. The student replied:

> STUDENT: I agree with the above, however, I am confident and assertive where I know that my actions are both safe and appropriate. If I am slower and more careful sometimes it is because I want to do the right thing for my patients whilst maintaining proper dignity and safety. I feel that as my skills grow so will my confidence.

Similarly, after a comment stating that she had developed confidence but needed to reach potential with assertiveness in the formative assessment of her third placement, S030801 wrote:

> STUDENT: I have ostensibly developed in confidence since beginning here, but lack of confidence has never been an issue with me, it was a question of the staff getting used to me and trusting in my abilities as a mature student nurse. I have learnt to develop strategies for getting what I need from this placement, there have been some staff willing to help. Initially I did not know what I needed to achieve from this placement setting, but now I do know and will extract what I need from here and hopefully it will assist me towards becoming a nurse.

In a later placement the same student rebutted a mentor's criticism of her making excuses:

> STUDENT: I thought I was giving mitigating circumstances as opposed to making excuses!! [exclamation marks in the original]

Communication between the mentor and the student broke down in this case and the self-assessments were written after the mentor's feedback, however, it is clear that students had a forum for disagreeing with their assessments.

#### 5.5.3.2. The student can change

Not only can the student challenge the assessment but also the clear consensus from the participants is that the student *can* change and improve. KI1 saw the ISP as a way of capturing borderline students and helping them to become better nurses:

P31:KI1 (17:17)
KI1: And I don't know whether all those students have necessarily failed or if they need to fail but I think when they're on the borderline, by not doing anything about it we've lost that opportunity to bring them up to standard, because actually, if you tackle those students and you do an action plan, then they are often the ones where you can see a vast improvement, by letting it drift, it's not even necessarily the issue that we've failed to fail a student that was unsafe it's perhaps that we've missed an opportunity to get the absolute best out of a student. They could perhaps be better than they end up being if someone had gone, you know what, this student just needs a little bit more…

PEF01 reported that mentors were acknowledging and addressing issues around behaviour sooner in the placement since the introduction of the ISP. For her this meant that students were not being allowed to progress through the programme without first improving:

P21: PEF01 F-up (34:34)
PEF01: […] What I've noticed is that any behaviour issues that are flagged up and potentially failed on this are early in the first year. Very few, I think I can recall one in the last that has progressed beyond the first year. So once it is dealt with and they failed on this because of their behaviour they seem to improve.

M01 directly ascribed improvement in some students she had worked with to the ISP:

P1: M01 (50:52)
M01: But this, I do feel that this document does help, but it also helps to motivate as well. It is nice to get feedback about how you are doing.
KM: So you think the students who are at the better end feel motivated.
M01: Definitely, even those who aren't the fact that I have seen an improvement in their performance because of this...(taps ISP)

There was some question about the sustainability of changes that students may have made in order to pass the ISP, PEF02 wondered if the behaviours might be repeated in later placements:

P22: PEF02 (85:85)
PEF02: […], possibly I have seen some improvement, but whether or not that would be sustained improvement I wouldn't like to say, there might be able to do it for the three months while they're on the ward to pass, whether or not they would then do it on other placements....

And EC1 had a student who did not maintain the changes:

P16: EC1 (61:65)
EC1: …they failed her formative but she passed on the summative
KM: and has she changed any of those behaviours?
EC1: yeah, for that ward, but then when she went on the next ward I saw her mentor and they said she'd come in wearing bellbottom trousers and trainers, so it's almost as if she changed her behaviour to pass the ward and then has gone back again

However, as the student will be assessed on the same tool in the next setting, presumably she will need to make the same changes again or she will not succeed. EC1 discussed another student who had not sustained a change and was failed in the next placement:

> P16: EC1 (13:13)
> EC1: …so the mentor was not going to sign the student off because she felt she couldn't leave the student alone with a group of patients. That the student didn't have the motivation, they didn't have the organisational skills to be able to do this…
> KM: so was she circling things in the fail or this part here? (I point to the lower scored items)
> EC1: things like displays a negative attitude [item 3], appears to lack motivation [item 5], does not define own learning needs [item 6] things like that, but these are all the same things that the student failed on the last ward

### *5.5.4. Challenges to CMO4*

CMO4 focuses more on variability of the people—mentors and students—involved and their experiences and expectations rather than inconsistencies in the practice setting. The mechanisms highlighted were **clarity** and **feedback** and the outcome that the student could change and/or challenge their assessment. However, as has been touched upon above in challenges to CMO2 [section 5.3.4] not everyone who uses it, understands the tool in the same way.

The idea that the ISP provides **clarity** has been challenged on several fronts. The borderline items have had a mixed reception [see also 5.3.4.1], for instance, PEF02 stated that while they sometimes confused mentors, they were also frequently used items:

> P21: PEF01 F-up (12:12)
> PEF01: Okay it is the ones with 9, 10, 11 and 12[24] next to them, they find that bit confusing because in the first year it is a pass and in the second and third year it is a fail. There have been some errors there but most of those do tend to be the commonest one they use. They certainly use the confidence one and the experience, they do use the one about how they react to criticism, they sometimes use the slow to settle and sometimes use the maturity.

And M04 described them as 'murky' [p. 153] although ultimately acknowledging that borderline items allowed assessors to reflect students' progress through the programme. Other mentors actively liked the option, M12 saying:

> P12: M12 (193:193)

[24] Some of the borderline pass first year/fail year second and third year. 9 Lack of confidence inhibits effective performance; 10 needs more experience at this level; 11 reacts adversely to constructive criticism; 12 slow to settle

> M12: I guess if you have got a problem student who is borderline it is a good idea because you can say "well look we'll pass you this time but you are borderline and you have to remember that in the second year this would be a fail."

Some aspects of the tool itself [see Appendix A p. 255] could be presented differently [see Discussion on suggested changes 7.8] and different HEIs have adapted it in various ways. For instance at Coventry University, borderline items have been removed and assessors must select pass or fail for each item, with a few having an option to denote distinction in practice (the number and range of items varies with years on the programme) (Coventry University, 2012). Other HEIs have removed the grading leaving only pass or fail options, for instance, the University of Western England paramedic programme has removed all grading leaving only the items numbered from one to 39 (University of Western England, 2012). [See Appendix H for examples from both universities.]

Despite participants suggesting that the tool clarified the assessment of interpersonal skills [sections 5.5.2.1 and 5.2.2.1], the precise meaning of some items was blurred at times. In the documents and interviews, mentors frequently referred to a student's initiative or being proactive but there is no item containing those words, instead some used '*well-motivated and adaptable'* (25 p), '*has made a useful contribution to the work of the team*' (28 p/g) or *'identifies own learning needs'* (27 p/g).

Equally, several concepts are each represented by several items e.g. *team working* (22p 28p/g 36 g/e[25]); *confidence* (9f/p 18p 30g and possibly 14p on assertiveness[26]); *motivation* (5f ,25p and possibly 17p *willing to try*[27]); and *maturity* (13f/p 24p 35g/e[28]). The items appear on different gradations and mentors sometimes chose more than one in the same assessment, possibly reflecting different nuances of the items, for instance 22 p '*fits well into the team'* and 28 or and 36 g/e '*valued team member who has gained respect'*, making it unclear what the key feedback was. Regardless, if either or both 22 or 28 are selected, the student can see that they have effectively worked in a team.

[25] 36 valued team member who has gained respect
[26] 9 lack of confidence inhibits effective performance; 14 needs to be more assertive; 18 has developed in confidence; 30 displays confidence
[27] 5 appears to lack motivation
[28] 13 lacks maturity; 24 displays a mature attitude; 35 shows a mature understanding

Maturity is not a straight-forward concept, as evidenced by multiple definitions in the Oxford English Dictionary (2011), e.g. 1) fully developed physically, 2) having reached a stage of mental or emotional development characteristic of an adult, 3) (of thought and planning) careful and thorough. The ISP has three items relating to maturity [see p. 255] and, in interviews, participants described maturity in several ways; as having insight into their behaviour, having previous healthcare experience and as also as being (chronologically) older. M12's comments reflected the complexity of the concept referring to age, life experience and experience in the health and social care setting:

> P12: M12 (87:89)
> M12: […], she's [a student who is unable to sustain enthusiasm for areas she is not interested in] still quite young. She still lives at home. My first year's completely different, she is a bit more of a mature student and we were saying this with a couple of other mentors. We've got some very young first years and we've got some sort of older first years and we find that they work completely differently […] compared to my first year who's got a background in social work, she's got a three year old daughter, she's a bit more of a mature person, she works completely differently whereas this other first year…she's new, it's her first time away from home, she's only eighteen so I think it's maturity […]. And we've got another first year who is the same as the…she's about eighteen, nineteen but her parents are both nurses. They're Mental Health nurses but it doesn't really matter. She's got some more of an idea of what's expected of her I think.

Most participants did not emphasise chronological age of the student but linked previous life experience or experience working in a healthcare setting. PEF08 asserted:

> P30:PEF08 (137:137)
> PEF08: I think in my experience of many years of students I don't think maturity has got anything at all to do with age, I think maturity is a state of mind, it's to do with the life experience students come across, I've had very a young student nurse who come straight out of school/college/a-levels whatever, straight into nursing had lost her mother at a very young age and brought up her younger sisters and so she was 19-20 but had got a huge amount of life experience and I've had 'mature' students who are incredibly childish and you know throw the toys out of the pram at the first opportunity so I don't think maturity is anything to do with age I think it's more of a state of mind, it's more to do with your personality than anything else..

Maturity was associated with being confident in the practice setting and therefore being able to focus and develop clinical and other skills:

> P4: M04 (48:48)
> M04: Yes you can explore because in some ways it doesn't disadvantage people who haven't been in [a healthcare setting] before but I think they feel that they have got a lot more ground. Equally it is about being confident on the ward in practice. They are learning all the routines almost, or the how the ward works, the basic day to day...This goes over there...What does this do?

Some identified that those with no previous healthcare work experience were intimidated and this impeded their learning, especially early on:

> P8: M08 (25:25)
> M08: When I meet the student for the first time I try to get a bit more information like why you want to do nursing? Why didn't you fancy doing something else? What made you [inaudible] any inspiration or anything, why you have to do this? So things like this, so as you speak to them or as asking them in your family has anybody been nurses, anything about nurses or before you come in. […] They used to come in "oh I'm really scared, this is my first hospital experience and I haven't got a clue." So you can support them more, once you come to the student, come to know them how much support they need so depending on that we can spend more time with them you see.

They did see however that confidence could increase with experience:

> P9: M09 (87:87)
> M09: My last, my girl [student] who was a week in…I can remember I put that she…something about confidence, needs to gain confidence but I said "you are a week in so you know…" and her mentor after me said exactly the same thing so she came back to me, I said "you're very new you know, you're eighteen, you've just come in fresh, the confidence will come the more that you learn" and it did, it did come a little bit while she was with me but I said "you just need a little bit more to trust your instincts and kind of do what you think you need to do because you know how to do it and you are trying to do it, you just need to get…" Yes, so, it is difficult

While having previous experience was mostly raised as an advantage, M04 explained that it came with its own risks [as did M05 on p. 151]:

> P4: M04 (56:56)
> M04: […] Equally you might have someone who is very confident that you almost then want to kind of...right okay. We have had people who have been quite, not over-confident but they come across as really...not in your face but almost... "I can do that, I can do that". Okay then, this is what we are going to do, you go and do that admission, I want you to do all the paperwork, all the observations, I want you to tell me what you think is going on and see how they go. By the time they come back and they say "how much of this paperwork do I have to do?" "Well you've got half an hour and you've got to complete all of that, I want to see a set of obs [vital signs], and if you have done an ECG before carry on with that as well, what are you going to do for this patient now?" Actually I don't quite know where I am now, and at this point this student had done it … was kind of like she said "I hadn't realised what was going on" and I said "no that's fine, you're learning". That's why sometimes you need to sit back and say I need to sit back and see it from a different perspective.

Students' ability to self assess is important in many self-regulating professions [see section 2.2.4], however, this aspect is not well defined on the ISP or clearly understood by mentors. What is meant by '*realistic evaluation of own performance*' (33 g) or '*is able to reflect on outcomes*' (26 p/g)? Some mentors mentioned reflection in their comments but select 33 as an item, e.g. S030804's mentor on the formative ISP for module 4 selected 33 and said:

> MENTOR: "[…] and is able to reflect on her practice in a useful and valuable way."

This concept is further complicated by 'awareness of own boundaries/ limitations' that crops up in mentor comments and is sometimes accompanied by 26 or 33 but sometimes by no number that seems related to the concept, for example S030804's formative ISP for module 3, item 21p, '*accepts appropriate responsibility*', the mentor commented:

> MENTOR: […] she is very aware of own limitations and is happy to perform new tasks under appropriate supervision i.e. removal of [device].

This awareness of limitations, boundaries or weaknesses was also sometimes associated with 27 p/g, '*identifies own learning needs'*. These are all reasonable definitions but may actually be reflecting a range of concepts.

Perhaps the strength of the ISP is that regardless of the finer detail, the point (about reflection, or awareness of limitations etc.) is being raised and identified to the student. Inconsistency in the way it is used or in understanding of the ISP may not be a drawback but rather may support the flexible use of the tool, enabling the mentor to critically comment on or highlight achievement in interpersonal skills [see Discussion 7.7].

A sub-mechanism of **clarity** was that **evidence** was provided for item selections. This evidence, however, was inconsistently delivered. KI1 also noted this issue:

> P31: KI1 (45:45)
> KI1: […] well certainly the ones that I've seen the evidence tends to be, I don't know that I've ever really seen evidence, what I would call evidence. I would say to mentors, like at a mentor update or if a mentor asks me about it, if you're saying the student has problems with time keeping, list down the dates on which they were late for work so when the student comes to you and says no I'm always on time you can say well no actually it wasn't 20 past seven it was half past seven, when we're saying evidence, that's what we mean, you need to be able to give the student examples so if you say to the student oh your manners with the visitors can be a bit abrupt for example, on such and such a day when Mr. Smith's relatives asked for a cup of tea and you said they couldn't have one they had to go to the canteen and what I try to say to mentors is the evidence is more examples really, it's being able to say to the student, this is what I'm thinking, let me give you an example so you can see what I mean, so the student can't say, oh your just saying that, I'm never late for work and I'm always lovely. The mentor can say actually no, these are the occasions I'm referring

PEF03 suggested that mentors needed to be supported in learning how to provide evidence:

> P24: PEF03 (194:194)
> PEF03: […] I think that's why we need to actually work on improving evidence to support the subjectivity of picking a category and I'd like to see people have better examples to support, more examples of why they've got a problem […]

From the documentary analysis it is clear that there was huge variation in how mentors provided evidence to support the items selected. Some mentors changed the way they provided evidence between formative and the summative assessments. Instead of providing evidence for the items selected, some mentors parroted the language of the descriptors from the items in the ISP, which may not have provided students with much information about what they had done well or what still required improvement. In this example for a second year student, the feedback echoed the ISP items and while fairly positive, did not support learning, as it was not clear what the student could do to do to further develop:

> S090709 module 5 Formative ISP
> 17p. 19p, 21p, 23p, 25p[29]
> MENTOR: He is willing to try and skills will come with development of practice. He is willing to accept responsibilities when needed. He is pleasant and appropriate in manner. He is well motivated.
>
> S090709 module 5 Summative assessment
> 17p, 21p, 23p, 26p (p/g), 27p[30]
> MENTOR: He is willing to try new skills. He is willing to accept appropriate responsibility. He is pleasant and approachable in manner. He is able to reflect on his outcomes. He is able to identify his own learning needs.

Using the items numbers to indicate which comment the evidence is supporting, some mentors made it very clear. Others selected five numbers and wrote a statement in the evidence box that may or may not have been related to the numbers selected. Occasionally mentors selected lower numbers on the scale but did not refer to them in the comments. Others put clinical skills details in the interpersonal skills comment boxes thus blurring the separation between performance criteria and interpersonal skills. Very few comments contained a developmental component that would allow the student to see what was required of them to improve. Mentors may well have been discussing issues with students verbally, however, without documenting them it was impossible to know.

The second mechanism of giving feedback to students was stressed by the majority of respondents as being an important part of the way the ISP works. However, KI2 identified that this feedback itself may not always have been clear to the student and they may have missed the point:

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[29] 17 willing to try; 19 skills will develop with practice; 21 accepts appropriate responsibility; 23 has a pleasant and approachable manner; 25 well-motivated and adaptable

[30] 26 is able to reflect on outcomes; 27 identifies own learning needs

P32: KI2 (10:10)
KI2: yeah, they are relatively positive or if they do pick up on something negative it'll be something that's almost mundane, like I tested them on one medicine and they didn't know the side effects and it's obvious that wasn't the issue, ok, maybe that's true but there is also the student was late, made mistakes and they haven't mentioned those things, they'll mention something that the student can achieve in a day, they can go and read a book and come back and answer the question but it's missing the point because that's not really, because someone really shouldn't fail for that, but if you assess them and they don't know, fine, but they can sort that out really quickly and you think well what about the other things? How is their care? The knowledge will come and yeah it is important they know those sort of things but if you're just highlighting that as an issue then why have you ticked these other boxes and that's what I see?
KM: so you're seeing mixed messages coming from the mentors?
KI2: yes, that's exactly what it is, well certainly documented. Maybe it's not when they're face to face, maybe they get told […] I'll ask them [the ECs] to go in to sort it out to ask the mentors to have a chat and then hopefully that'll give it enough time for it to be documented properly and for the student to know where they stand because the student might not realise that they're failing, they might think that if the mentor is telling them they need more time, they might not see that as a problem, and when I tell them that is a problem it comes as a shock…

M01 described how she used the ISP hypothetically, supporting the idea that mentors may be talking to students about their assessments but that these comments may not have been documented [see PEF08's advice to mentors p. 133]:

P1: M01(80:80)
M01: […] if you need to chivvy somebody up a bit [motivate] you could say "well you are here at the moment; I need to really see you up here." Because you're here…

Furthermore, in a number of the submitted documents, the comments appeared to be written for the benefit of the HEI rather than the student, identifying students in the third person and repeating words from the item descriptors, thus adding to the confusion about what should have been documented, and for whom.

Student practice assessment documents also include other components [see Appendix B] including learning contracts and action plans. The ISP is a separate tool but developmental issues raised there could logically become part of action plans or learning contracts. As PEF07 identified, perhaps there would be more development and improvement if the feedback from the tool were translated into a plan for student learning:

P29: PEF07 (117:117)
PEF07: …I think if it's the interpersonal skills that they've actually identified there is already the grid there, so I think that's where they kind of yeah so all through the placement they're actually picking them out [KM: right] there is a box where they then make comments so they comment in there rather than using the action plan for that
KM: so when they give the examples about why they chose them (PEF07: yeah) that's telling the student this is where the deficit in your behaviour is
PEF07: yeah, so it is documented but not documented from what I can see in the learning contract

The ISP is not a perfect tool but most of the challenges identified do not invalidate the core mechanisms that the requirements around assessment of interpersonal skills tends to be clearer than previously and that the evidence and feedback both formatively and summatively contribute to students' understanding and ability to learn from and/or challenge this assessment.

#### *5.5.5. Conclusion CMO4*

The interplay between mentor and student is complex but the ISP might mediate this complexity through **clarity** and **feedback** allowing the student both to improve or change their interpersonal skills and to challenge unfair assessments.

## 5.6. Findings conclusion

Four broad groups of context issues emerged from the analysis, some of which are also raised in the Literature Review [see section 2.3.2.1], and will be further examined in the next chapter [section 6.2.1]. There is a grouping around mitigating mentor weaknesses [see section 5.3.1], including preparedness for the role, junior level of mentors and the closeness of the assessor-assessed relationship. Variability was also an important context issue, both in the practice settings [see section 5.4.1.1] and in mentor's expectations and students' experiences [see section 5.4.5]. However, the context that underpins all the CMO configurations is the ephemeral nature of interpersonal skills and the difficulty in assessing them [see section 5.2.1].

Mechanisms by which the ISP may be effective in supporting the assessment of interpersonal skills but which may apply equally to any tool that triggers such mechanisms [see section 6.2] are that for borderline mentors it provides **distance** for the assessor from the personalisation of the assessment; **prompts** them to assess and **legitimises** their doing so. In the rich variety of practice settings it is a **leveller** and **enabler** making assessment faster and easier. Expectations are given **clarity** and **feedback** is formative and motivating and **evidenced**. Finally, being more **explicit**, it gives mentors **permission** to assess interpersonal skills, a **place to document** the assessment and has summative **consequences** for the student,

which may be seen as a reward or punishment for interpersonal skills.

A main outcome is that interpersonal skills are overtly assessed, which, according to virtually all participants and in my own experience, as both nursing faculty and supporter of mentors, did not happen routinely or explicitly prior to the introduction of the tool. A second outcome, that hinges on the main outcome of visible and overt assessment [see generative causation section 3.3.1] is that students can challenge and change from the feedback they receive [explored in CMO4, chapter 5.4.5]. Demonstrating the ability of the CMO configurations to encompass complex situations, an intermediate outcome related to increased mentor confidence (pentagon in Figure 14, p. 112), was identified as an outcome in CMO2 [section 5.3.3] and a mechanism in CMO1 [section 5.2.3.1].

# 6. Developing Theoretical Models

In this chapter the mechanisms identified in the Findings [chapter 5] are further abstracted to develop theoretical models from this study that contribute new knowledge in this area . Firstly, the changing contexts and outcomes throughout the study are represented by a 'spiral of raised awareness'. The 'spiral' stands in contrast to criticism that realistic evaluation fails to address complexity (Barnes et al., 2003) [see section 7.2 for more detail]. The second part of this chapter explores middle range theories abstracted from the mechanisms identified in the CMO configurations in the Findings chapter.

## 6.1. The Spiral of Raised Awareness

In the Findings [chapter 5], four CMOs were identified and explored. An overarching framework of raised awareness of interpersonal skills [Figure 19 below] is here conceptualised to encompass the CMOs, demonstrating that Realistic Evaluation can deal with complex systems. These relationships are hypothesised based on the data analysis and the way in which contexts, mechanisms and outcomes have an impact upon each other. The CMOs are envisaged as a series of separate but interlocking configurations that influence each other, with raised awareness forming the outer piece of the puzzle.

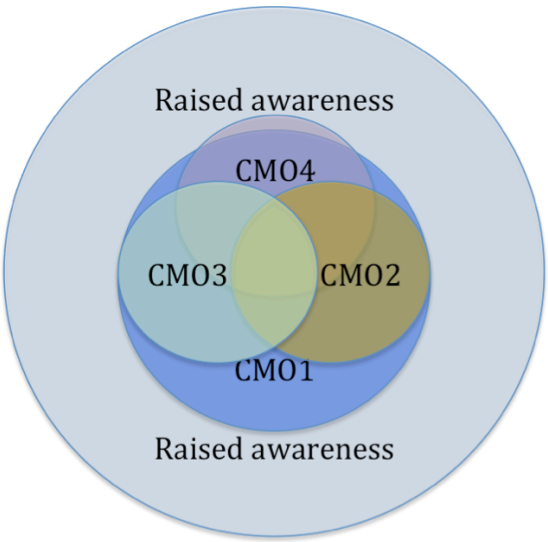


***Figure 19 CMOs surrounded by raised awareness***

This framework is further conceptualised as a 'spiral of raised awareness' [see Figure 20 below]. The spiral is a positive feedback cycle: a cycle in which the response increases the original stimulus, which further increases the response. For instance, the mechanism that makes the requirements of interpersonal skills assessment more explicit not only gives mentors permission to actually assess interpersonal skills [see section 5.2.2.2], but is also the outcome of the assessment for students who can see and challenge and learn from this assessment [see sections 5.5.3.1 and 5.5.3.2].

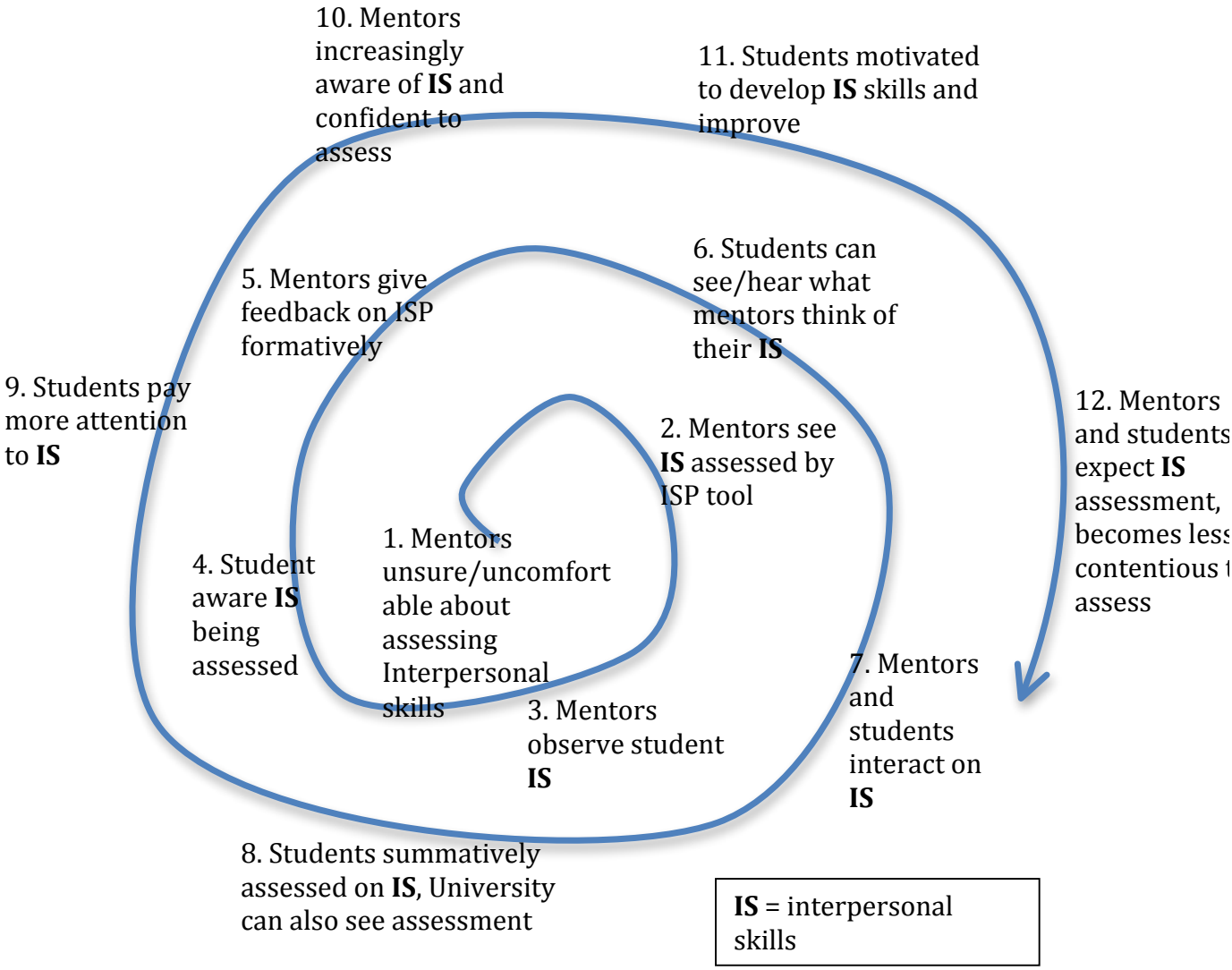


***Figure 20 The Spiral of raised awareness***

This spiral of raised awareness is not itself a context, mechanism or outcome but rather addresses each aspect:

- Due to the introduction of the ISP, a *context* of the study is that interpersonal skills assessment was pushed to the forefront of assessment procedures for the first time. Any mentor and student looking at a practice assessment document can see that there is a tool to assess interpersonal skills, thus raising awareness.
- Raised awareness is at the same time a *mechanism* of the tool; through raising awareness for both mentors and students, interpersonal skills became a part of clinical practice development and assessment. The fact that people are thinking and talking about it further increases the awareness of interpersonal skills and their role in practice
- Thus an *outcome* of the mechanism is both a further and an increased awareness of interpersonal skills and the assessment of them.

The starting point is that mentors, both weak and experienced, are uncomfortable and uncertain about assessing interpersonal skills [sections 5.2.1 and 5.3.1] and assessments are infrequent or incomplete. As the tool is introduced mentors feel legitimised to assess interpersonal skills [section 5.3.2.3] and in turn they observe this aspect of students' practice. At the same time students also see the interpersonal skills profile in their documents and [hopefully] have been informed about it in the HEI. Mentors feel able to give formative feedback on interpersonal skills [section 5.5.2.2]. Students are less defensive or surprised by such feedback [section 5.5.2.1.1] and can hear what the mentor is saying. The student and mentor interact (this may be an improvement, challenge, reward etc.) and a summative assessment is completed [section 5.2.3.2 and 5.4.3]. As students submit practice documents, personal tutors at the university who see the assessments, may also challenge or support or become aware of the students' achievement. As it becomes a routine part of the assessment the students pay more attention to interpersonal skills, as do mentors who become increasingly confident to discuss and assess them. Students can be motivated to improve skills (although some may be disheartened and de-motivated with poor assessments) [section 5.5.3.2]. Over time interpersonal skills no longer seem so alien and contentious to assess. As with most positive feedback cycles, once the pinnacle is achieved—in this case assessment of interpersonal skills becomes routine—some of the mechanisms become redundant. However, as there is a constant turn over of mentors with

varying levels of confidence and self-awareness (Pellatt, 2006; Myall et al., 2008) the tool will remain a constant reminder or prompt for the necessity of interpersonal skills assessment as well as a means to do it. Furthermore, students coming into the programme continue to need to become aware that interpersonal skills are actually assessed. The ISP can be seen as a learning tool for both students and mentors [further explored in section 7.7] and may provide scaffolding (Spouse, 1998) to support the routine integration and development of interpersonal skills assessment in practice [see section 6.1.1].

Real life is not linear and stable, and factors rarely occur sequentially but often influence each other in a variety of ways. The CMO configurations and the spiral are a way to step out of reality and examine ideas behind what is working for whom, and why, before we plunge back into the daily business of supporting and assessing learners in practical settings.

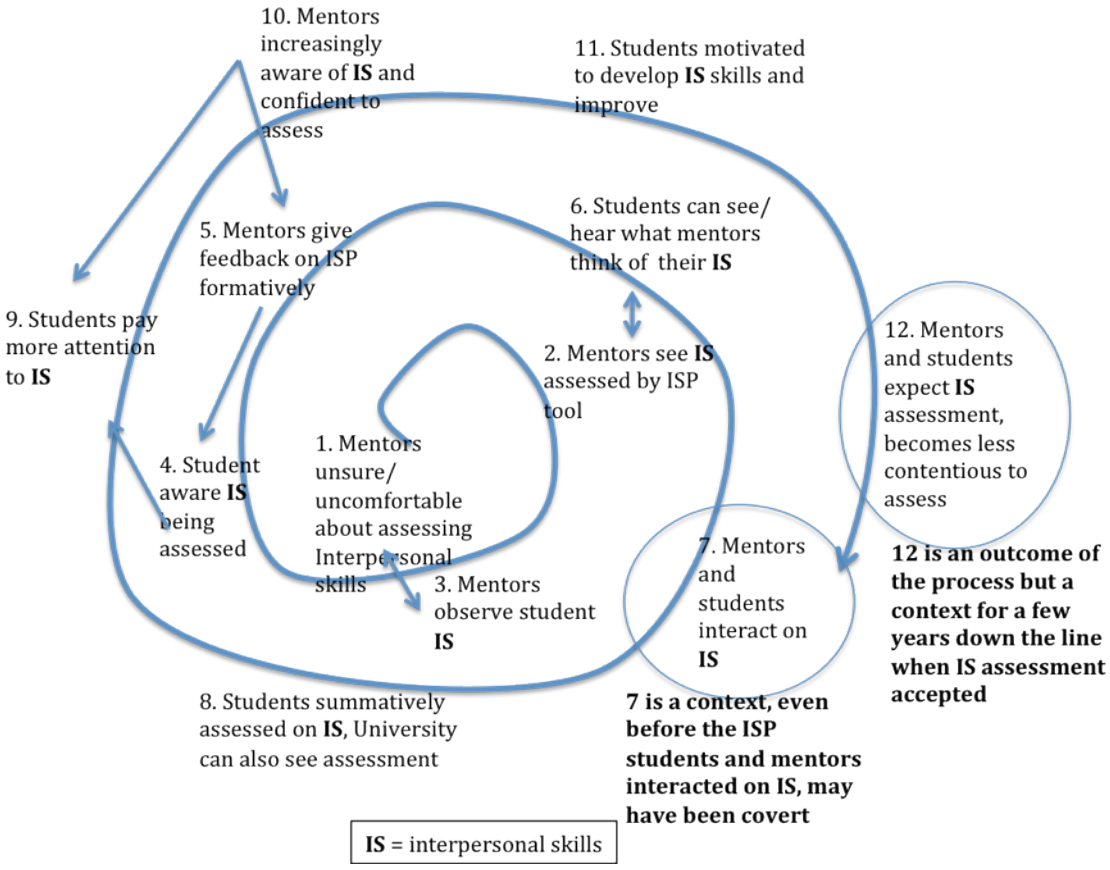


***Figure 21 Spiral of raised awareness with alternative connections***

The CMO configurations developed through the Realistic Evaluation approach are represented linearly in order to better present and discuss the related ideas. For

instance, looking at the spiral it may appear that there are steps that logically progress (indeed the items in Figure 20, p. 178 are numbered 1 through 12) however, this is again for ease of understanding. The interactions between the items could be presented differently as depicted in Figure 21.

### *6.1.1. Scaffolding*

The ISP may be providing a 'scaffold' on which mentors can build confidence and/or competence in assessing interpersonal skills. Scaffolding is an idea in educational theory developed from Vygotsky's notion of the zone of proximal development (Chaiklin, 2003). The zone of proximal development refers to the notion that if a learner is supported to develop beyond what they currently know/can do, then they will eventually be able to know it/do it on their own. A simple definition is given by Vygotsky himself "*what the child [learner] is able to do in collaboration today he will be able to do independently tomorrow*" (1934 cited in Chaiklin, 2003, p. 40). Thus scaffolding refers to educational strategies that support learners to develop and can be discarded when no longer needed. This concept emerged from theorizing about children's learning but has since been applied to adult learning (Spouse, 1998; Engestrom, 2000; Edwards, 2007). As is discussed below, one of the main mechanism families to emerge from the data [see section 6.2.5] encompasses various ways to support mentors to learn to and gain confidence to overtly assess students' interpersonal skills.

## 6.2. Mechanism families –middle range theory

Further abstracting from the data [see section 4.1.1] and findings discussed in chapter 5, three middle range theories (MRTs) were developed in this study. MRTs are common in nursing (Smith & Liehr, 2008) and are arguably the highest level of abstraction that can be developed from research into contextually-bound practical research questions (Boudon, 1991). Boudon (1991) argues that the search for overarching independent variables that operate in all social processes is fruitless, but that clear middle range theories can organise a set of hypotheses and relate them to empirical findings in a way that others can find useful and that can enable

those findings to be used in other settings. MRTs also fit with the research approach; Heathfield (2001) defines the aim of Realistic Evaluation as:

> "[⋯] to produce some middle-range theory in the form of context, mechanism and outcome configurations, which is abstract enough to underpin the development of a range of clinical systems, but concrete enough to withstand testing in the details of system implementation." (Heathfield, 2001, p. 12)

By grouping the mechanisms discussed in the Findings [chapter 5] into three 'mechanism families' (Pedersen & Rieper, 2008), each examining an underpinning thread, three 'middle range theories' of how a tool can support the assessment of interpersonal skills are proposed. Firstly, the broad contextual factors are reviewed followed by a brief discussion of outcomes. Then each mechanism family: 'Making it over' [section 6.2.4], 'Providing support' [section 6.2.5] and 'Feedback-feed forward' [section 6.2.6] is examined in turn.

### *6.2.1. Contexts*

As discussed in the Introduction [section 1.2] and Literature Review [section 2.3.1], nursing is one of many professions in which a large proportion of the training is spent in practice. Implementation of the practical component of professional education varies both between and within professions. However, differences are not only between professions or HEIs; even students who are on the same programme will have a wide range of experiences (Wilson & Scammell, 2010; Galbraith et al., 2011). Not only is it is difficult to standardise the student experience, but equally it is a challenge to prepare assessors to the same standards (Govaerts et al., 2011; Huybrecht et al., 2011).

Interpersonal skills are tenuous, difficult to describe and subjective (Epstein & Hundert, 2002; Knight, 2006; Jette et al., 2007). Unlike exam or essay questions, interpersonal interactions are also fleeting and unrecorded, we can only rely upon the recall of those involved (Shapton, 2007). Nevertheless practitioners recognise interpersonal skills as important (Chambers, 1998; Mann et al., 2005) and research suggests they should be assessed. For instance, some medical education literature suggests that problems in interpersonal skills (e.g. poor initiative and impaired relationships with students, residents, faculty, and nurses) as a student can be predictive of professional disciplinary action further in their professional career

(Papadakis et al., 2005; Teherani et al., 2005; Teherani et al., 2009). In a survey of over 1,900 mentors for the Nursing Times (a UK nursing journal), 69% reported that attitude (e.g. work ethic, time keeping) was the worst area of student skill and aptitude (Gainsbury, 2010). Compounding this difficulty is the challenge of mentor preparation. As Ginsburg and colleague identify (2010, p. 784), in the context of practice or the workplace, subjectivity is inevitable therefore assessment should start with what the assessor actually observes, rather than trying to 'standardise' these perceptions away. This suggests it is unlikely that all assessors can be identically trained and prepared in assessment procedures. In pre-registration nursing practice in the UK there are a broad range of practice settings with variable support from mentors, each with differing levels of preparation and interest in supporting students. The proposed mechanism families function within these contexts; some enable and others inhibit the mechanisms to support assessment of interpersonal skills.

### *6.2.2. Enabling and disabling contexts identified in the study*

In this study, interpersonal skills were seen as ephemeral, difficult to define and uncomfortable to assess [Findings 5.2.1.1 and 5.3.1]. Furthermore assessors felt ill-prepared to undertake the assessment and were unsure that it was even wanted by the HEI [Findings 5.2.1.2]. Even confident, strong mentors felt challenged by the documentation, the practice settings in which they worked and the pressures of work and time [Findings 5.4.1.1]. Thus, disabling factors for assessment of interpersonal skills were the practical setting; the assessors' own training; their experience and level of confidence; and the nature of what was being assessed itself.

Outside of the ISP itself, factors that enabled the assessment of interpersonal skills were the enthusiasm and engagement of the mentor; settings where they felt prepared and confident in their own judgement; and areas that welcomed students. Other broader factors included the NMC's SLAiP standards (2008b; 2006) and the push by both clinical areas and the HEI to better prepare mentors. Several study participants (M04, M12, PEF04, PEF05, PEF08, KI1) referred by name to Kathleen Duffy's report on 'Failing to Fail' students in the practice setting

(Duffy, 2003), demonstrating an awareness of the zeitgeist surrounding the assessment of students in practice.

Situational factors also provide important disabling context. In placements of two weeks or less, the nuanced grade of interpersonal skills are a challenge to assess as explained by mentor M02

> P2: M02 (180:182)
> M02: Some of it [the ISP is achievable] but I don't think all of it you will…, because, for example, display confidence I don't think they will do that for a week […] So you cannot really…
> KM: So maybe not the higher ends of things?
> M02: No, maybe some along [looking at doc]…needs to be more assertive in a week, maybe not. Maybe in two weeks you could but in a week it is quite a short time […]

Specialist areas also reported a challenge in terms of using items at the top of the ISP scale as students were not, for instance, able to demonstrate that they could be '*innovative, develops fresh ideas'* (item 37) or show that they were '*capable of informed decision-making'* (item 34) [see section 5.4.4.].

Other barriers addressed by the supportive mechanisms such as having no place to document concerns, struggling with the language to use, feeling too close to the student to be able to comment and others, are discussed in section 6.2.5.

### *6.2.3. Outcomes*

Prior to the introduction of the ISP in the placement documentation, interpersonal skills may have been addressed but in a haphazard and poorly documented way. This is common in areas that do not specifically include interpersonal skills, attitudes and behaviours in their assessment (Cross, 1998; Coll et al., 2002; Regehr et al., 2007). The main outcome of the study was therefore that interpersonal skills were *overtly* assessed. This outcome was enabled by a mechanism, increased mentor confidence [section 5.2.3.1], which was itself an outcome of the mechanisms of increased support, discussed in section 6.2.5. This main outcome itself is a mechanism for the further outcome that students can change and challenge their assessments [Findings sections 5.5.3.1, 5.5.3.2 and Figure 14, p. 112].

### *6.2.4. Middle range theory 1: Making it overt*

Prior to the introduction of the ISP in the practice documentation, interpersonal skills may have been assessed. Some respondents (for instance M01, M04, M05, M08) specifically stated that they had always done so. However, what is not clear is how this was done, where it was documented and if the student was aware of the assessment. What the ISP seems to be doing is making the assessment of interpersonal skills *overt*. Those involved in the assessment after the introduction of the ISP were aware that interpersonal skills were actually being assessed and were able to identify what was expected. This transparency can create a potential for learning dialogue between assessor and learner (Gillespie, 2005). Although some are ambiguous (what exactly constitutes a '*pleasant and approachable manner*' item 23), the fact of there being descriptors opens up an awareness of an expectation and a possibility for the mentor and student to discuss these expectations. In Kathleen Duffy's renowned study on 'Failing to Fail' (2003), she reported:

> "Certainly the lack of overt reference in the assessment document to the importance of attitude was the reason one mentor in the present study felt they had to pass a student […]" (Duffy, 2003, p. 67)

In the same report, Duffy goes on to suggest:

> "It would appear prudent to recommend that learning outcomes pertinent to professional behaviour and attitude be given prominence within assessment documentation." (Duffy, 2003, p. 67)

In the study reported in this thesis, overt-ness is achieved through several mechanisms discussed below.

By being **explicit** [Findings 5.2.2.1], the ISP brings the assessment of interpersonal skills to the surface of the practice learning experience [see Appendix A p. 255]. Assessors can see that they are expected to comment on aspects such as maturity (items 13, 24 and 35[31]) or teamwork (items 22, 28 and 36[32]) or responsibility for learning (items 6 and 27[33]). Being explicit has been a successful assessment strategy in other settings. For instance, in trying to decrease grade inflation, Weaver and colleagues found that clinical assessors on medical placements more

[31] 13 lacks maturity; 24 displays a mature attitude; 35 shows a mature understanding
[32] 22 fits well into the team; 28; has made a useful contribution to the work of the team; 36 valued team member who has gained respect
[33] 6 does not define own learning needs; 27 identifies own learning needs

accurately assessed students when the 'learning card' included explicit instructions on what each grade banding meant (2007). Clear and explicit language is also important in surgical education, where a tool, the NTOSS (Non-technical Skills for Surgeons) was developed, driven by reports of 'avoidable deaths' caused by poor communication and other human errors, (Beard et al., 2011). A stated aim of the NOTSS is to: "*provide surgeons with a structure and with the language to observe, rate, and provide feedback on behaviors during routine cases*" (Yule et al., 2008a, p. 554). In various settings, the majority of assessors (consultant surgeons, independent assessors and scrub nurses) agreed that the tool did so, allowing assessors and trainees to communicate more clearly (Yule et al., 2008b; Beard et al., 2011).

Furthermore, the explicit nature of the ISP means that learners can see what skills they are required to demonstrate and—if necessary—to learn (Springer et al., 1998). This was demonstrated in an American study of medical interns who had completed medical school. Their performance in talking to patients improved after receiving explicit instruction on a card:

> "When talking to this patient, please be as empathetic, understanding and open-ended as possible. Give the patient time to talk and deal with his feelings, home, and work situations as appropriate. Integrate this overall, patient-oriented style into a sound medical interview." (Kauss et al., 1981, p. 664).

Being overt means the hidden curriculum of expectations of professionalism and behaviour in the practical setting, which are frequently assumed, are surfaced (Tsang, 2011).

Although the ISP is evidently not *absolutely* clear [section 5.5.4], the mechanism of **clarity** [Findings 5.5.2.1] was identified as important. The ISP forms part of the assessment document for every part of the programme, both formatively and summatively, it is apparent to all that interpersonal skills are an important part of the assessment. Mentors can also develop familiarity with the tool and perhaps increased confidence using it (Cross et al., 2001).

Finally there is a **levelling** [Findings 5.4.2.1] mechanism that does not overcome but can minimise the great variability between practical experiences [section 5.4.1.1]. All placements in the study pre-registration nursing programme are

required to assess using the ISP, regardless of field, acuity of the setting, and module on the programme. This means that interpersonal skills are not linked to a particular aspect or type of nursing but reinforces that interpersonal skills permeate all of a nurses' (or any) professional practice. While assessment remains a local practice (Knight & Yorke, 2008), the ISP can provide some consistency to assess –at least the lower scoring items [see discussion of limitations in specialist areas or short placements sections 5.4.4 and 6.2.2]—in a variety of settings.

Abstracting from the particular context of pre-registration student nurses in one HEI it is proposed:

**Summary of MRT 1:** Making requirements about assessing interpersonal skills clear to students and assessors, can enable overt assessment and learning.

### *6.2.5. Middle range theory 2: Providing support*

Despite the many barriers to assessing interpersonal skills that were identified in section 6.2.1, another group of mechanisms seems to revolve around supporting the mentor, both practically and emotionally, to actually complete the assessment.

A **place to document** [5.2.2.3] is a pragmatic mechanism that literally allows assessors to capture their thoughts. Previously, mentors reported that they could not fail students if the problem was not in the documentation. In a study of grading practices in another UK institution, Scammell et al. reported a similar finding after a change in documentation (2007) with an educator reporting:

> "[… a mentor] had a student who last year got through because although she was advised about attitude and conduct she could still get through…whereas this year I could have referred her." (Scammell et al., 2007, p. 38)

In a qualitative study looking at why GPs and consultants failed to give critical feedback to students, they reported being inhibited by a lack of documentation (Cleland et al., 2008). Furthermore, mentors may be verbally reporting feedback [see section 5.5.4] without documenting it. Hemmer et al. (2000 cited in Hodges et al., 2011, p. 357) observed oral evaluations of medical students and noted that they contained more comments on professionalism and behaviour than did rating forms or checklists. Circling an item on the ISP and writing a comment in evidence

may assist in documenting this conversation. A **place to document** the transitory and intangible aspects of practical education can be a mechanism to support overt assessment.

The **prompt** mechanism [Findings 5.3.2.2] lies between practical and emotional support. By existing in every practice document twice, for the midpoint and the summative assessment, the ISP serves as a visual reminder that the assessment must take place. However, it also suggests to the mentor that they should observe interpersonal skills in the continuous assessment [see section 2.3.1.2] of the student. Prompting is important in that assessors may not consciously look at attitudes and behaviours if they do not feel they form part of the assessment. In a doctoral study of social work students in the UK, Finch (2009) observed:

> "[⋯] it was clear that whilst practice assessors could identify what behaviours could be potentially problematic in practice learning settings, they then failed to notice or effectively manage those very same behaviours in the student they worked with." (Finch, 2009, p. 36)

**Enabling** functions on two levels. Firstly, in this study mentors found it easier to select items from a list than to have to generate their own responses. Research on nurse mentors in Belgium also found that they did not feel comfortable writing their own comments and found report writing time consuming (Huybrecht et al., 2011). Parker (2003) found that if given a blank space to write feedback, mentors provided non-specific or unhelpful comments, and sometimes no feedback was provided at all, even when failing students. Respondents in this study mentioned that the ISP made assessment of interpersonal skills quicker and easier. Writing reports and trying to find the right language to capture the assessment can be time consuming and assessors may choose not to document failing or marginal behaviours (Hicks et al., 2005; Stokes, 2005; Regehr et al., 2011; Hunt et al., 2012).

The second practical aspect of **enabling** is simplicity. Research has demonstrated that assessors frequently do not use lengthy or complicated assessment documentation (Calman et al., 2002; Huybrecht et al., 2011; Hunt et al., 2012), a finding supported in this study by M05 [p. 144] who suggested detailed assessments do not get done as well or as often. When evaluating tools for physiotherapy student practice assessment, Cross and colleagues (2001) went so

far as to discard the three pages of criteria that accompanied one of them, based on the anecdotal report that they were not being used in practice. In their sample only 25% of assessors said they had used the (discarded) criteria in their assessments. As has also been seen in the development of rubrics for use in practice (Isaacson & Stacy, 2009), these studies suggest that tools that are simple to use are more likely to be used and to support the assessment process.

Four further mechanisms in this family provide emotional support. The ISP gives mentors a **distance** from which to assess interpersonal skills [Findings 5.3.2.1]. The one-to-one relationship between mentors and students and the face-to-face verbal assessment are emotionally difficult. Mentors work closely with students and often continue to do so after the assessment period. The ISP provides a way for them to initiate difficult conversations, without it seeming like they are personally attacking the student. **Permission** [Findings 5.2.2.2] and **legitimises** [Findings 5.3.2.3] are two closely aligned mechanisms that function by reinforcing to the mentor that they are allowed to assess such subjective aspects as interpersonal skills (Ilott & Murphy, 1997) and that they are not alone; all mentors are required to do so. Finally, by including items related to motivation, confidence and response to criticism in the tool with clear **consequences** [see section 6.2.6 below], the academic institution is sending a clear signal to practice assessors that failure, or indeed reward, is an option. This is not always evident to mentors in practice. Canadian registered nurses who precept students (but have no formal assessment role) reported that they avoided giving critical feedback on interpersonal skills as they felt it was not a clear part of their role and students reacted personally (Hanlon, 2009). Assessors in various professions and countries with formal assessment roles reported that they were concerned universities would overturn their decisions regarding fails in practice and therefore did not do so (Barnard, 2004; Stokes, 2005; Finch, 2009; Fitzgerald et al., 2010; Govaerts et al., 2011; Regehr et al., 2011; Heaslip & Scammell, 2012). In the Nursing Times survey [see above p. 189], 31% of mentors believed the university would overturn a fail (Gainsbury, 2010).

As discussed above [section 6.2.3] these mechanisms increase mentor confidence in assessing interpersonal skills. However, ***increased mentor confidence*** is also a

mechanism that supports mentors to overtly assess interpersonal skills. Reluctance to fail or give critical feedback on attitudes, behaviours and interpersonal skills has been associated with a lack of confidence (Scanlan et al., 2001; Luhanga et al., 2008a; Finch, 2009; Hunt et al., 2012) and having little experience (Duke, 1996; Ilott & Murphy, 1997; McCarthy & Murphy, 2008)

**Summary of MRT 2:** A tool to assess interpersonal skills that is provided in practice assessment documentation can support assessors both practically and emotionally.

### *6.2.6. Middle range theory 3: Feedback—feed forward*

The ISP is used both for formative and summative assessment. Some theories of assessment suggest that different tools should be used for each, as midpoint and final assessments have different purposes (van Mook et al., 2009c; Galbraith et al., 2011; Norcini et al., 2011). However, in practice, where the assessors have little access to training it is simpler to use the same tool for both assessments (Dalton et al., 2009; Hawkins et al., 2009). Ideally, if a midpoint assessment is completed, the student can use the formative **feedback** as a benchmark for what they might achieve in the summative assessment. For the mentor and the student, the **consequences of assessment** can clearly be seen; some items will result in a fail while others indicate superior performance. In this study mentors reported enjoying being able to reward good practice and believed it could stimulate students' motivation [section 5.5.2.2]. In their study on grading practice, Scammell and Heaslip (2009, slide 10) reported a mentor saying "*[it was] satisfying to give graded feedback, to indicate whether they are a borderline pass or are really excelling"* and that grading practice *"Gives students something to aim for*". In the same study a student commented:

> "[…] when I am given a pass I sometime feel that it is not enough because I know I really worked hard and although my practice educator has given me feedback that I have done really well it is only the pass that comes up on my results – if students knew they could get an excellent grade then I think they would work even harder." (Wilson & Scammell, 2010, p. 97)

Students often have a hard time hearing and taking on board **feedback** (Eva et al., 2011; Regehr et al., 2011; Heaslip & Scammell, 2012) and the intention of the mentor to 'feed forward' to the summative or next assessment can be lost (Knight, 2006). Because of this difficulty in assimilating critical feedback the mechanism of **evidence** was also important. Because there is a **place to document** the reasons behind the choice of items selected [see sections 5.2.2.3 and 6.2.5] there is a record for students to return to and potentially learn from or to challenge if it is perceived of as unfair. From the documentary analysis it could be seen that **evidence** was not always well executed [see section 5.4.4]. Nor, from personal experience and comments from students on a quantitative evaluation of the whole assessment document [see section 2.4.1] does feedback always happen constructively or in a timely manner. However, the requirement to provide evidence for the selection of items supports a level of transparency and clarity [see MRT 1, section 6.2.4] that allows the student to either take on board the comments or to challenge them.

Traditional summative assessments often measure something other than what evaluators are actually looking for: measures may be reliable but not valid (Broadfoot, 2001; Knight, 2001; Neighbour, 2003). Furthermore, not everything worth learning is measurable, and the purpose of assessment should be to support learning (Lambert & Lines, 2000; Broadfoot, 2001; Neighbour, 2003). Reflecting the different agendas of practical and academic learning, Millar (1985) said: "*nurses rely on implicit knowledge, nurses see that nursing is what nurses do, while educationalists see it as what nurses ought to do*" (cited in Andrews & Jones, 1996, p. 358). The ISP allows nurses to decide what nursing is and make that knowledge explicit, in effect handing over to the practitioner, instead of the HEI ever more tightly defining criteria.

**Summary of MRT 3**: Overt feedback and written evidence that has clear consequence can feed-forward and be motivating to students. It can allow students to assimilate feedback and develop their practice or constructively challenge potentially biased feedback.

## 6.3. Developing Theoretical Models conclusion

Data from interviews and documentary analysis were analysed retroductively (Kazi, 2003), to search for the mechanisms underpinning the outcomes of the use of the ISP by mentors in practice. These mechanisms were further abstracted to identify what might work for other professions in similar practical settings.

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Through this back and forth process two main conceptual models were developed. The first, the spiral of raised awareness [see section 6.1] explored how contexts were constantly shifting and how they were affected by mechanisms. The second model produced three simple middle range theories [section 6.2] of what works in an assessment tool, supporting the assessment of interpersonal skills in a professional practice setting.

# 7. Discussion

## 7.1. Discussion overview

This study examined how an assessment tool, the Interpersonal Skills Profile [ISP], was used to assess interpersonal skills in pre-registration nursing students at one English HEI [see Introduction 1.3, Methodology 3.6, and Appendix A p. 255] using a Realistic Evaluation approach, grounded in critical realism. This approach embraces context, highlighting confounding or particular factors for all to see. Paradoxically then, those factors can be bracketed and the data abstracted to uncover more general mechanisms that may or may not facilitate the assessment of interpersonal skills. The reader can decide if the mechanisms would have an effect in his or her own particular context. Using a retroductive approach to analysing data [section 4.2.1] from interviews with mentors, PEFs, ECs and KIs as well as documentary analysis of student placement documents [see section 3.6 for details of research participants], four CMO configurations were identified [see Findings chapter 5]. Within these configurations 13 mechanisms describing how the ISP might support the assessment of interpersonal skills in practice were examined. In chapter 6, theoretical ideas were further developed. Firstly, a model of a 'spiral of raised awareness' was generated in order to explore the complex ways in which context, mechanism and outcome interact [see section 6.1] and may provide a 'scaffold' for mentors to learn to assess interpersonal skills [section 6.1.1]. Secondly, three middle range theories [MRTs, sections 6.2.4, 6.2.5, and 6.2.6] were proposed. They suggest which mechanisms triggered by the ISP might support overt assessment of interpersonal skills in practice assessment settings. The Discussion chapter examines key points raised in the Findings in the light of literature available on the subject. These are examined both in relation to nursing and healthcare education and also professional education in general [see Literature Review 2.2].

The research questions are revisited in the next section. A critique of the inability of Realistic Evaluation to handle complexity is rebutted in section 7.3. Then in section 7.4 the ISP is examined from the perspective of assessment *for* learning (A*f*L) and compared to criteria for authentic assessment (Baartman et al., 2007).

The professional gatekeeper role of assessors and the preparation of mentors are briefly addressed [section 7.5] along with a discussion of bias and subjectivity in assessment [section 7.6] and the mitigating role of evidence for assessment [section 7.6.1]. A few suggestions for changes to the ISP are proposed [section 7.8] and the idea of the ISP as a *learning* tool for all parties is explored [section 7.7].

## 7.2. Revisiting the research questions

This section revisits each research question, highlighting the main findings, links to other research and the new insights contributed by this doctoral study. The primary research question [see p. 59] asked:

**How is a tool designed to assess the interpersonal skills of pre-registration nursing students used in practice?**

This question and the secondary research questions below, arose from personal experience in an academic role before being refined through the Literature review [chapter 2]. Personal experience included assessment of interpersonal skills before and during the introduction of the ISP, the tool which provided the focus for this study [see section 2.4 and Appendix A for the ISP and Appendix B for the context of assessment at the study HEI]. The Literature Review [particularly sections 2.3.2.1, 2.3.2.2 and 2.3.2.3] revealed gaps in research relating specifically to the ISP and more generally, assessment of interpersonal skills. The form of this study's research questions was influenced by the Realistic Evaluation research approach [section 3.3] and data analysis focused on identifying CMO configurations [section 4.1]. Thus the primary research question was answered by first addressing three secondary questions:

- **Secondary question 1:** What are the contexts which inhibit or enable the assessment of interpersonal skills in practice?
- **Secondary question 2:** Through what mechanisms does a tool to assess interpersonal skills facilitate their assessment in practice?
- **Secondary question 3:** What are the outcomes of using the interpersonal skills profile?

The Findings [chapter 5] explored the three secondary questions in detail, elucidating contexts, mechanisms and outcomes of use of the ISP and framing them into four CMO configurations. The secondary questions will be reviewed below.

### *7.2.1.* ***Secondary question 1:*** *What are the contexts which inhibit or enable the assessment of interpersonal skills in practice?*

Four main contexts affecting the assessment of interpersonal skills were identified and formed the basis for development of each CMO. The key context highlighted in CMO1 '*Interpersonal skills are hard to assess*' [section 5.2.1.1], was that interpersonal skills were seen as difficult to assess as found in previous research [see section 2.3.2.1]. All interviewees discussed difficulty in identifying exactly what constituted an interpersonal skill and potential for bias in assessing interpersonal skills [see section 2.3.2.2]. Barriers to assessing interpersonal skills also included the feeling that the HEI was not interested in feedback on interpersonal skills, replicating a finding reported in Hanlon's (2009) doctoral study on nurse preceptors in the US, but not found in the wider literature.

In CMO2 '*Mitigating mentor weaknesses*' [section 5.3.1] the context centred more on the experience and engagement of the mentor with the student and the closeness of the mentor-student relationship. Some research participants used the term 'borderline mentor' to describe mentors who struggled with student teaching and assessment. This new term was derived from the notion of 'borderline students', a phrase commonly used in clinical practice and academic settings to describe students who are struggling, but are neither clearly passing nor clearly failing. Research in a variety of fields on borderline students has focused on the difficulty of identifying borderline students through assessment tools and the associated emotional labour of mentors (related to identification, providing support and remediation) (Ilott & Murphy, 1997; Shay, 2008; Finch, 2009; Govaerts et al., 2011). Research participants in this study adapted the idea of 'borderline students' to mentors highlighting the similarities between students and mentors who struggle. There are several concepts in common: the lack of clarity around what defines borderline, the notion that there could be an improvement with support and education, and difficulty in deciding if the person (student or mentor) is competent in a variety of situations. In addition, 'borderline mentors',

are those who lack confidence in their assessments, who feel awkward giving critical feedback or who provide it in such a way that the student may not be able to accept it. The term has not been found in the literature, but researchers such as Govaerts et al. (2011) and Finch (2009) describe such mentors in their work. The term 'borderline mentor' became an important analytical concept in the study and may usefully encapsulate characteristics and circumstances that would benefit further research and other professional support. In this study, the term came from confident participants and mentors who described having developed their own comfort with and skills to assess students over time.

Context in CMO3 '*Clinical setting variability*' [section 5.4.1.1] focussed on variations in placement areas such as time on placement, busyness of the ward and degree of specialist knowledge in use in the placement [see section 2.3.2]. There was insufficient data to be able to comment on differences between particular fields of nursing, however, several interviewees pointed out that interpersonal skills are difficult to assess in very short placements as mentors do not get to know the student. Research on assessment in practice has identified clinical acuity, low staffing and time pressures as barriers to assessment (e.g. Levitt-Jones et al., 208; Hodges et al., 2011; Regehr et al., 2011). Some interviewees felt that the specialist nature of some placements made it difficult for students to demonstrate very good or excellent interpersonal skills. Similarly PEF03 was concerned that specialist areas might confuse particular competence in their area with general competence causing them to assess students too harshly [see section 5.4.4]

Finally, CMO4: '*Variability of mentors' experiences and students' expectations*' [section 5.5.1] focused on the context of the variability of mentors' experience and of students' expectations. Much research on student assessment in practice focuses on mentor preparation [see section 2.3.1.2 and further 7.5.1], the difficulty in preparing assessors equally and ensuring standards are met. In this study and supported in the literature (Martimianakis et al., 2009; Twenge, 2009; Hodges et al., 2011), it was clear that mentors bring expectations of student behaviours and skills rooted in what was usual in their own training. However, as professional education has evolved over time, expectations have changed. Generally, mentors had different expectations of students in the first year from those in later years on

the programme, acknowledging that time is needed for students to develop confidence. Tanicala et al. (2011) also reported that mentors expect students to progress, reflecting that interpersonal skills are not static but need to be developed. Furthermore, in this study, interviewees noted that just as the level of mentor preparation varies, students were sometimes observed to be ill-prepared for placements and did not understand their own paperwork. In section 7.8 a suggestion is made that students be better prepared for assessment in practice.

As explored in the 'spiral of raised awareness' [section 6.1], the ISP might alter all of these contexts through increasing awareness of interpersonal skills and their assessment for both mentors and students. Mentors' assessment skills also develop over time.

### *7.2.2. **Secondary question 2:** Through what mechanisms does a tool to assess interpersonal skills facilitate their assessment in practice?*

The mechanisms identified in the study tended to be those that facilitated the assessment of interpersonal skills. In the Realistic Evaluation approach, mechanisms do not represent infallible laws but are a way to discuss tendencies seen in the data [section 3.3.3]. In this spirit, each CMO was also challenged to identify ways in which mechanisms did *not* facilitate interpersonal skills assessment [see sections 5.2.4, 5.3.4, 5.4.4 and 5.5.4]. In the development of MRTs [in sections 6.2.4, 6.2.5 and 6.2.6] the literature was also explored for these mechanisms.

CMO1: '*Interpersonal skills are hard to assess*' encompassed four mechanisms; that what and when to assess is **explicit**, mentors have **permission to assess**, there is **a place to document**, and the **consequences of the assessment** are clear to mentors and students. As discussed above [section 7.2.1] interpersonal skills are not easy to define and categorise. In CMO1 the mechanisms are around making what *is* being assessed explicit, giving mentors permission to assess what might appear to be subjective and biased, and giving them an obvious place to do so. Students are also given a clear indication of what is expected of them in practice and notice that it will be assessed. The idea of needing to make criteria more explicit has been raised in the literature (for example, Alexander, 1996; Weaver et

al. 2007) however, the other mechanisms identified in CMO1 have not been addressed in the literature on assessing interpersonal skills.

CMO2: '*Mitigating mentor weaknesses'* comprised three mechanisms that support borderline mentors; the ISP provides **distance**, **prompts** assessment and **legitimises** assessment of interpersonal skills. These mechanisms address the emotional labour of assessment (Hunt et al., 2012) through providing distance from the close relationship between mentor and student [section 5.3.1.1]; through legitimising interpersonal skills as an area for assessment in practice and because the ISP form acts as a physical reminder. These mechanisms, which make interpersonal skills easier to assess, have not previously been discussed in the literature.

CMO3: '*Clinical setting variability*' contains two mechanisms: **levelling** between different areas and **enabling** assessment. Important differences between placement areas remain and problems in specialist areas or very short placements have been discussed above [section 7.2.1]. The ISP 'levels' by normalising interpersonal skills assessment as routine in all placements and 'enables' through making assessment quicker and easier undertake. This is important because time-consuming or complex assessments, no matter how reliable and valid, have poor adherence (Cross, 2001; Calman et al., 2002; Huybrecht et al., 2011; Hunt et al., 2012)

CMO4: '*Variability of mentors' experiences and students' expectations*' had four mechanisms; the ISP provides **clarity** through requiring **evidence**, supports the giving of **feedback** and students are aware of the **consequences of assessment**. Evidence is a key requirement of the ISP and a way in which judgements on a subjective area can be fairly presented to the student and the HEI. The data analysis demonstrated that evidence was not always well documented; however, the requirement for concrete examples can protect the student against unfairly negative assessments. Documents showed that a few students used the self-assessment section of the ISP to reply to mentors' comments. Documents cannot provide evidence for *the way in which* students were assessed, but research on giving feedback, (particularly Branch and Paranjape's (2002) notions of brief,

formal and major feedback) is examined in section 7.4.1.

Several mechanisms, such as clarity and being explicit seem to reflect different facets of a process which might be supporting the assessment of interpersonal skills. Some are very practical, such as a place to document and the visual prompt as a reminder to assess. Others suggest more emotional support through providing distance and normalising the assessment of interpersonal skills as a legitimate part of the mentor's role. In section 7.4 the mechanisms are compared to the literature on 'authentic assessment' (van der Vleuten, 1996; van der Vleuten & Schuwirth, 2005; Baartman et al., 2007; van Mook et al., 2009c) and assessment *for* learning (Norcini et al., 2011; Roberts, 2011; Yorke, 2011) suggesting ways in which the ISP is both a way to facilitate authentic assessment and assessment *for* students' learning.

### *7.2.3.* ***Secondary question 3:*** *What are the outcomes of using the interpersonal skills profile?*

Two main outcomes were ascribed to the use of the ISP in practice. The first, explored in CMOs 1 and 3, is that interpersonal skills were *overtly* assessed [sections 5.2.3.2 and 5.4.5]. The claim is not that interpersonal skills were never previously assessed [see section 2.3.2.2], but that the ISP makes their assessment more transparent to stakeholders in the assessment process. An increase in mentor confidence through the supportive and normalising mechanism of the ISP is identified in CMOs 1 and 2 as an outcome that also functions as a mechanism [sections 5.2.3.1 and 5.3.3 and Figure 14, on p. 112]. The second main outcome focused on students. In CMO4 it was hypothesised that the overt-ness of the ISP would allow students to challenge their assessment or improve their interpersonal skills through having received feedback [section 5.5.3]. This outcome was inferred from participants' accounts of students and from a small number of comments in the documents submitted by students, but in the future could be explored through an observational, longitudinal study or a study with student participants.

### *7.2.4. Developing additional conceptual models to answer the research questions*

In chapter 6, the concepts identified in the Findings [chapter 5] were developed further, effectively a fourth level of analysis [section 4.3]. The 'spiral of raised awareness' [see Figure 20 in section 6.1] is one attempt to answer the primary research question, about the way that the ISP might actually be functioning in practice and influencing the assessment of interpersonal skills. The model considers ways in which contexts, mechanisms and outcomes interconnect and interact. This will be discussed further in section 7.3. The spiral portrays a type of feedback, reflecting the changing situation arising from the impact of the intervention (the ISP) progressively (although not necessarily linearly) changing the mechanisms which it triggers.

Abstracting from the mechanisms which were closely connected to the study context, three MRTs (summarised below) were proposed. A tool such as the ISP will improve the assessment of interpersonal skills because it will:

1) Make requirements about interpersonal skills assessment explicit to assessors and learners [see MRT 1 section 6.2.4]
2) Consider ways in which the documentation can support assessors both practically and emotionally to undertake what are often perceived as difficult and subjective assessments [see MRT 2 section 6.2.5]
3) Make feedback as clear and explicit as possible so learners can learn from it and develop their interpersonal skills over the course of their programme [see MRT 3 section 6.2.6]

Stepping back from the particular context of how the ISP is used in practice in one area enables theories to be proposed of what mechanisms (triggered by the ISP but possible with other types of assessment tools) more generally support the assessment of interpersonal skills in workplace-based assessments.

How is the ISP used in practice? The ISP seems to facilitate the overt assessment of interpersonal skills by supporting mentors in several practical and emotional ways. Secondly, because it provides a way for comments to be documented and it requires some evidence to support item selection, the ISP can potentially protect against unfair treatment of students. Students can also become more self-aware

and learn to recognise the importance of interpersonal skills and professional behaviour, which may allow them to improve their performance.

## 7.3. Critique of Realistic Evaluation

While Realistic Evaluation is increasingly used in healthcare and education research (Byng et al., 2008; Moore & Bridger, 2008; Thistleton, 2008; Jolly et al., 2009; Long, 2009; Melton, 2009; Hogg, 2010; Pommier et al., 2010; Rycroft-Malone et al., 2010) it is not without its critics [see 3.3.3.1]. Davis (2005) and Hansen (2005) suggest that Realistic Evaluation is insufficiently operationalised and cannot deal with complex systems. Dickinson (2006) further suggests that CMO configurations are too linear and Barnes et al (2003) that they are unable to deal with contested meanings. While supporting Realistic Evaluation as a research methodology Rycroft-Malone and colleagues (2010) also find making the distinction between context and mechanism problematic. Barnes et al. (2003) and Dickinson (2006) suggest that Realistic Evaluation does not operate within the 'open systems' of real life as imagined in critical realist ontology [see 3.2]. Barnes and colleagues (2003, p. 269) describe C+M=O configurations as unidirectional and therefore not reflective of the possibility that context is itself subject to change due to the impact of the programme (or intervention) under study. Dickinson (2006, p. 381) also suggests that the way in which Realistic Evaluation conceives of context artificially 'closes the container' of the phenomenon under study making it more like the model of a closed experiment.

However, in this study, the fluidity between context and mechanism was useful: the approach did not seem to close the system but left the context inside the field of study. As in Byng and colleagues' (2008; 2005) study, Realistic Evaluation was flexible, allowing the researcher to conceptualise aspects sometimes as mechanisms and sometimes as contexts [see sections on CMOs in Findings, Figure 14, p. 112]. Furthermore, in contrast to the concerns of Barnes and colleagues (2003), a particular strength of the approach was that mechanisms and outcomes could be identified even as the context changed through the very implementation of the tool being evaluated [see spiral of raised awareness Figure 20, p. 178 and Figure 21, p. 180]. In this study, far from being linear, CMOs were conceived of as interconnecting and having an impact upon each other, even if they were pulled

apart for clarity of presentation in the Findings [chapter 5]. The development of the spiral of raised awareness [section 6.1] demonstrates how they have been put back together and how they interact.

## 7.4. Assessment *for* learning

Assessment has long been recognised to have an impact on learning, both on what students value, and on what teachers choose to emphasise (Boud, 1995; Watling & Lingard, 2010). Colloquially it has been said to be the "*tail that wags the dog*" (Norcini et al., 2011, p. 208). Facing up to this has meant that educators now focus on producing assessment *for* learning (A*f*L), not *of* learning (Norcini et al., 2011; Roberts, 2011; Yorke, 2011). In their research in higher education in the UK, McDowell and colleagues (2011, p. 750) specifically link authentic assessment and A*f*L. Alongside authentic or 'relevant' assessments they describe A*f*L assessment environments as rich in formal and informal feedback; providing opportunities to try out skills and understanding, which helps students to develop independence and autonomy and has a balance between formative and summative assessment.

Over twenty years ago Miller introduced the influential notion of the assessment pyramid in medical education (Miller, 1990), emphasising the importance of assessing what the student actually does in practice [see Figure 22, p. 203]. He suggests that multiple choice questions and essays test what the student knows. OSCEs and structured clinical observations can identify what the student knows how to do (competence) or shows how to do (performance) but they rarely capture what the student *does* in the actual practice situation. *Does*, is at the top of the pyramid and is necessarily underpinned by knowledge and competence, but is seen to be difficult to describe and assess.

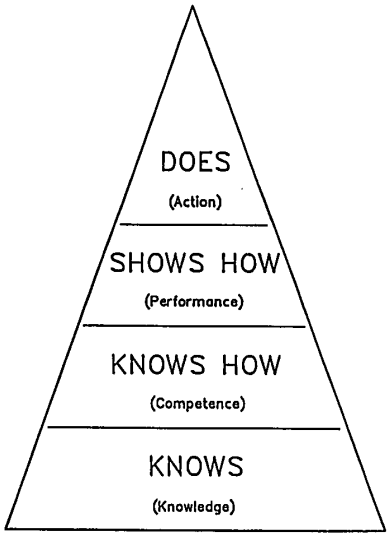


***Figure 1.* Framework for clinical assessment.**

***Figure 22 Miller's pyramid***
***(reproduced from Miller, 1990 p. S63)***

By definition, assessing what students are doing should be 'authentic' (Galbraith et al., 2011) and support learning. The ISP can assess the top of the pyramid because mentors who work with students frequently, carry out the assessment in the actual placement.

While attempting to shape assessment in support of learning, in their research on medical education, van der Vleuten and his team have identified many aspects of effective assessment which they term 'authentic assessment' (van der Vleuten, 1996; van der Vleuten & Schuwirth, 2005; Baartman et al., 2007; van Mook et al., 2009c). These researchers and others are also beginning to recognise the subjectivity and judgement inherent in all types of assessment (Bloxham, 2009; Bloxham et al., 2011; Yorke, 2011). Baartman and colleagues describe it this way:

> "Contrary to traditional testing, assessing competence always involves a domain expert's judgment and the main doubts regarding the reliability of competence assessment pertain [sic] just this reliance on human subjective judgments" (Baartman et al., 2007, p. 118).

Their studies have shown that repeated assessments by several assessors can increase the reliability of a tool, demonstrating that reliability is not an objective property of a particular tool (van der Vleuten & Schuwirth, 2005). They identify ten criteria for authentic assessment [see 2.3.2], and maintain that final high stakes decisions about progression should rest on multiple assessments with multiple

assessors in multiple contexts and situations, ideally with multiple tools. The ISP as used in the study HEI is examined in relation to each of the criteria identified in Baartman and colleagues' (2007) paper.

1. Authenticity: *Criteria should reflect competences needed in the (future) workplace.* Mentors, PEFs and ECs reported that the ISP captured aspects of nursing practice. As M09 said [see p. 117]

   "I personally think a lot of what nursing is about is on [the ISP]"

2. Cognitive complexity: *Assessment should reflect higher cognitive skills, to capture students' thinking processes*. The ISP is less strong on this point; although through discussion of the selected items with the mentor, students may be able demonstrate a rationale for their behaviour or simply explain the thinking behind it. For example, student S090702 explains her thinking as she uses the self-assessment section of the study site's ISP to provide a rationale for two borderline items selected by the mentor. The documentation reads:

   Item 8 [needs to take responsibility appropriate for this level]. MENTOR Needs to exhibit more motivation in selecting learning opportunities and learning outcomes. STUDENT *I felt I was learning about my learning outcomes by reading up on the resources available, i.e. catheter care worksheet and wound care books, I will try and be more motivated in asking for more opportunities*

   Item 15 [could have made more use of available resources]. MENTOR For example in the mornings could be looking at visit book, reading relevant journal articles rather than reading a novel STUDENT *At the start I was reading a book as I felt 'out of place' I realise now that it may have appeared like I was disinterested so I will take this on board*

3. Fairness: *Should reflect the knowledge, attitudes and skills of the competence and minimise bias*. As has been noted above, there are fears that the ISP can be too subjective, however, the transparency of the tool and the requirement for evidence go some way to satisfying this criterion [see section 5.5.2.1.2].

4. Meaningfulness: *Value for teacher and learners and future employers*. From responses of PEFs, ECs and mentors it was clear that they saw the ISP as assessing relevant aspects of nursing

   P30:PEF08 (69:69)
   PEF08: […] from my perspective as a district nurse when it came into practice I

> jumped for joy, I love it, and talking to mentors in practice they love it too. The reason they love it is because they've always had this grey area where you've had students who were very good clinically or and were very good academically but you just know that there is something not quite right, […], it isn't something that you can really pick up easily without seeming very subjective in the documentation but this scale gives you the perfect forum for it.

5. Directness: *Assessors should be able to immediately interpret the assessment results.* Although some mentors clearly require a bit more support in learning how to use the tool [see section 5.3.4.1] for the most part the consequences of assessment are clear to see [section 5.5.2.2].

6. Transparency: *The scoring criteria, purpose of assessment, and what is expected of them should be clear and understandable to all participants*. This has been identified as a main strength and mechanism of the ISP [see sections 5.2.2.1, 5.2.2.2 and 5.5.2.1].

7. Educational consequences: *What is the impact on learning and instruction? What is the evidence about intended and unintended positive and negative effects?* This study attempted to answer this question related to the ISP. There is evidence that students can change their behaviours, i.e. that there is a formative function [see section 5.5.3.2]. Unintended positive effects might be an earlier identification of problems and an increase in mentor confidence [see section 5.2.3.1]

> P18:EC3 (66:66)
> EC3: It's quite interesting actually, because attitude and the way they socialised into nursing is in my opinion being picked up earlier, these things are being ironed out a lot sooner, people are more comfortable now, whereas before it was a bit of a pass on things, I think this has been, mentors working with us has made them more accountable and at the first formative if there is an issue that is flagged up then they sometimes contact us but invariably they try and work it out

   Unintended negative effects are the repetitiveness of the assessment for some students who are doing well. This was mentioned by a few students in the web-based survey of the whole HEI assessment document [see Literature Review 2.4.1] and was mentioned in follow-up interviews with PEF01 and PEF03.

8. Reproducibility of decisions: *For high-stakes assessments* [such as nursing qualification and license to practice]*, performance should be assessed multiple times, by multiple assessors over a sampling of tasks*. In this study nursing

students are being 'continually assessed', as is standard in the UK [see 2.3.1.2] meaning that the two official assessment points, the midpoint (formative) and summative at the end of placement should reflect observations over the entire placement rather than instances of practice. As the ISP is in the students' practice assessment for every module, there are multiple assessments. At present, in the study HEI it is not clear that assessors see prior assessments or if the final (sign-off) assessor will review previous assessments, but the potential to do so is inherent in the tool.

9. Comparability: *The assessment should be conducted in a consistent and responsible way. The assessment should be based on a set of tasks that, though not identical, are consistent with respect to key features of interest.* Introduction of mentors to the ISP is haphazard; due to the difficulties presented by attempting to reach all mentors and train them, many may see it for the first time only when the student provides their placement document. It is also difficult to guarantee that mentors are assessing the same aspects of interpersonal skills. However, the requirement to provide evidence should mitigate some of the differences that can emerge between mentors [see section 5.5.2.1.2.]

10. Cost and efficiency: *This criterion relates to the manageability of assessment tasks.* In nursing, there are large numbers of students and funding is not as high as for some other professions [see section 2.3.1]. The ISP is a tool that can easily be added to any assessment tool that covers more specific technical or clinical skills and is much cheaper than hiring patients or actors for standardised patient roles, or organising OSCEs (Leigh et al., 2007)

The ISP fulfils many of the criteria for authentic assessment, which makes it an assessment tool *for* learning. From the data analysis it emerged that this learning was not just for the student, but that assessors could also learn to pay more attention to concerns about interpersonal skills and articulate these, despite the ephemeral nature of interpersonal skills.

### *7.4.1. Feedback and evaluation*

A key mechanism of the ISP is to provide students with concrete feedback on their performance and to feed-forward so they can improve their performance [see section 6.2.6]. As M05 points out [p. 119] it is not necessarily the tool that is important; *how* it is used can be more relevant. For all the mechanisms that support assessment of interpersonal skills to happen in practice, it is possible that students still do not take on board feedback or that mentors do not provide it. Branch and Paranjape (2002) helpfully suggest ways of concretely supporting clinical teachers to give feedback to students. They differentiate between 'brief feedback' given in the moment about a particular task or skill, prefaced by "*let me give you some brief feedback*…" (Branch & Paranjape, 2002, p. 1185); 'formal feedback' in response to a particular teaching opportunity, mistake or episode that is prefaced by soliciting self feedback from the learner; and 'major feedback' which is scheduled, for example at the midpoint of a practical placement. They suggest that scheduled major feedback allows the student time to prepare, is appropriate for discussion about inappropriate behaviour or unprofessionalism and should be constructive with a plan for supporting remediation. This is different from evaluation which summarises where the student is, although it may also include plans for development or remediation.

The ISP is an excellent example of a tool that can facilitate 'major feedback'. Alongside the requirement for mentors to support their selections with evidence and particular examples, it contains a section for student self-assessment., Even though the self-assessment often seems to be completed after, and in response to, the mentors' assessment; it should still trigger an awareness in students that they must reflect on their own performance. Further research in this area is discussed in section 8.3.2.

## 7.5. Gatekeeper role of mentors

A category of 'borderline' or weak mentors who struggle with student assessment was identified in this study [see section, 5.3.1]. Although the focus of the study was not on mentor preparation [explored further below 7.5.1] and licensing these are worth further discussion. As was touched upon in the Literature Review [section 2.3.2.1] and the Findings [sections 5.2.4 and 0], not all mentors acted upon their

misgivings when assessing students who showed poor interpersonal skills, passing the student and giving the benefit of the doubt. One participant, M06, indicated that, previously, she was unaware that her assessments had any impact on the student's success or failure on the programme [see p. 115]. An official gatekeeping moment in the final placement the student undertakes has explicitly been identified for nursing in the UK since 2008. The NMC clarified that 'sign-off mentors' (who must meet additional criteria and who more explicitly "*make judgements about whether a student has achieved the required standards of proficiency for safe and effective practice for entry to the NMC register*" (NMC, 2008b, p. 7)) take responsibility for the clinical aspect of qualification whilst the HEI is responsible for the academic success or failure. If the ISP were used alongside a system for mentors to see previous assessments, it could also provide a way for the sign-off mentor to look back at the students' progression throughout the programme.

### *7.5.1. Mentor preparation*

Mentors make up an important part of nursing education and the preparation of mentors has been much studied and discussed in nursing in the UK (Myall et al., 2008; Webb & Shakespeare, 2008; Murray & Staniland, 2010; Wilson & Scammell, 2010; Tolley et al., 2011b; Heaslip & Scammell, 2012) and elsewhere (McAllister et al., 2008; McCarthy & Murphy, 2008; O'Connor et al., 2009; Huybrecht et al., 2011; Lovegrove & Hatfield, 2011). Common themes identified were lack of time (Warne et al., 2010) and remuneration (Mallik & Aylott, 2005) for training students and inadequate training in specific assessment strategies and documents (Hyatt et al., 2008). The current study did not attempt to study mentor preparation, however, as discussed in section 4.2.2.1 the difficulties in mentor preparation [see also section 2.3.1.2] form one of the contexts of this study [discussed in CMO4 section 5.5.1.1]. In professions with small numbers of practitioners it seems feasible to attempt to train them on the use of particular tools (e.g. physiotherapy in Australia and New Zealand, Dalton et al., 2011), but for those with a large or diffuse cadre of workplace-based assessors this is not achievable.

As suggested by MRT 3 [section 6.2.6], feedback is an important factor in a student being able to change their performance or challenge their assessment. Rather than

refining tools, mentors could be supported in learning techniques for giving feedback including the timing of assessments. If assessments are separated in time, using the same tool for both feedback and evaluation can have advantages [see p. 190]. However, it was clear in the documentary analysis [see p. 136] that at times formative and summative assessments were done very close together or even on the same day, making the assessments less about learning for the student.

Based on this study, it is suggested that general mentor preparation should focus on strategies for giving clear and timely feedback, and the distinction between feedback and evaluation, regardless of the tool selected. Such preparation would provide a clear assessment focus for all mentors but especially those who are weak and struggling.

## 7.6. Bias and subjectivity in assessment

Subjectivity and bias are two important aspects to consider about any assessment of interpersonal skills and particularly the ISP. PEF03 raised the point in her second interview saying

> P25: PEF03 F-up (35:35)
> PEF03: […] I didn't realise how much playing the game was important and I think you know, if students are having a problem now they are not going to go to their mentors because they are going to be judged on them. [p.151]

In his thinking on assessment in practice, Cassidy (2009) identifies both valid and invalid subjectivity of mentors. Mentors who do not invest in the relationship and are inattentive to what students are actually doing in the clinical area are described as having invalid subjectivity; their processes are problematic and could threaten the integrity of the assessment. However, in this study it has been demonstrated that because the mentor is obliged to write evidence to support the items selected and the student can appeal to a third party, the HEI, there is less of a risk of this kind of unfairness. The student may fail an assessment or possibly a module, but would be unlikely to inappropriately fail the entire programme: they would be given a chance to challenge the assessment or to remediate in the light of feedback. Only one student failed on the ISP in the documents submitted for analysis, and the fail was contested. In her self-assessments the student challenges the characterisation of her as defensive [see p. 165] and she was given an opportunity to begin the failed module again.

Positive bias or the 'halo' effect is also an observed phenomenon (Kuczewski, 2006; Hay & Macdonald, 2008; van Mook et al., 2009a; Ginsburg et al., 2010). In a study on work evaluations of police officers, King et al. (1980) found that even a rigorous procedure designed to remove the halo effect, failed to do so. They concluded that the best approach was to make the assessment explicit and give those being assessed an opportunity to answer back and reply to their assessments; the ISP provides those opportunities.

Bloxham (2009) and Yorke (2011) make the case that almost all assessment is somehow subjective. Ginsburg and colleagues (Ginsburg et al., 2010) suggest that instead of discarding holistic impressions by assessors in practice (in their study, consultant doctors), assessment methods should harness these impressions usefully. The ISP is a way to attempt to address the implicit assessment of interpersonal skills, which otherwise may be noted but not commented upon (Burack et al., 1999). The bias is not eliminated, but made plain for students, mentors and the HEI to see.

### *7.6.1. Evidence*

As mentioned in section 2.4, the study HEI added the requirement for evidence to the ISP. In addition to the importance of evidence from this study [see 5.5.2.1.2, and 5.5.3.1], a lecturer—at another university that uses the tool without a requirement for evidence—reported that students sometimes felt persecuted and that statements were used against them (Anonymous, 2008). The only way those students could overturn their assessments was if due process, such as timing of the midpoint assessment, had not been followed. As one of three main foci identified in a report on the 'Future of Medical Education in Canada', Regehr and colleagues identify the importance of supporting assessors to document their assessments:

> "In addressing the weaknesses of the current in-training evaluation model, the community would do well to move beyond faculty development strategies that teach supervisors how to use the tools, and address the administrative, professional, and cognitive barriers that impede supervisors' ability to formally codify and document their expert assessments of their trainees." (Regehr et al., 2011, p. 10)

Thus the study HEI's version of the ISP with a requirement for evidence is an important innovation that can support mentors to codify and document their assessments of interpersonal skills.

## 7.7. ISP as a learning tool

This study developed three middle range theories of how assessment of interpersonal skills in practice might be facilitated:

- **MRT 1:** Making requirements about assessing interpersonal skills clear to students and assessors, can enable overt assessment and learning. [section 6.2.4].
- **MRT 2:** A tool to assess interpersonal skills that is provided in practice assessment documentation can support assessors both practically and emotionally. [section 6.2.5].
- **MRT 3**: Overt feedback and written evidence that has clear consequences can feed-forward and be motivating to students. It can allow students to assimilate feedback and develop their practice; or constructively challenge potentially biased feedback. [section 6.2.6].

Additionally, the spiral of raised awareness [section 6.1] suggests that awareness of interpersonal skills itself enhances the performance and assessment of them. Thus the ISP can be conceived of as a learning tool for all those involved in the assessment of interpersonal skills as highlighted below.

- **The HEI** If the HEI spends more time and energy on familiarizing students with the assessment documentation [see suggestion 7.8] Discussions about the ISP and the items should ensure student awareness of the nature and impact of interpersonal skills. Awareness would be raised even before students set foot in a placement area (Gallagher, 2010). Personal tutors or small group facilitators would also be more aware of interpersonal skills in their own classes or groups and might comment and role model these skills in the HEI setting. The ISP could be used to assess student behaviour within small groups in the HEI setting.
- **The student/learner** As discussed in section 7.4, the learner can see that certain behaviours are expected of them (Eva & Regehr, 2008). Students may not always agree with their assessors as to what constitutes maturity, or a negative attitude (Newton et al., 2009; Twenge, 2009; Hodges et al.,

2011), however being aware that it forms part of assessment may open up a conversation rather than a defensive reaction to criticism (Norcini et al., 2011). With regard to the risk of unfair assessments, unfairness can be mitigated by getting two attempts at any assessment in theory or in practice [see 1.3.1.3]. The ISP ensures that students get a second chance to rectify even fails due to personality conflict or bias because they have the opportunity to see the rationale for the mentor's judgement.

- **The mentor**. KI1 provides a clear example of a mentor learning from the ISP whilst assessing a student [see p. 164]. Rather than HEIs or licensing bodies spending time and effort to get assessors to use particular tools perfectly, the ISP highlights that it may be possible to use simple tools and focus on training and support for giving feedback (Gibbon & Dearnley, 2010; Eva et al., 2011; Hunt et al., 2012) [section 7.4.1]. Commenting on interpersonal skills twice in a placement creates a potential for mentors to develop their skills at giving feedback and to identify what they think of as important interpersonal skills.

To reprise KI1's conclusion after a student and mentor had disagreed about the ISP assessment and KI1 had stepped in to mediate the situation she said:

> P31: KI1 (36:36)
> KI1: well it depends which way you look at it, if it [the ISP] hadn't have been there, I mean at the end of the day that student learnt a lot about herself, the mentor learnt a lot about herself as well, the mentor will have been a better mentor from that experience, the student then went on and did really well in her next placement, I think they gained from it.

And although she did not explicitly state it, in relating the story it seemed that KI1 as a personal tutor had also learned how to support both the mentor and student in practice.

## 7.8. Suggestion for changes to and support around the ISP

The aim of this study was to uncover mechanisms by which the tool was effective in facilitating the assessment of interpersonal skills. The argument is not that the ISP is the only tool that can do so successfully, nor is it about changing the detail of the items and their descriptors. The descriptors are quite open to interpretation, which may for some be perceived as a drawback, but in this study was seen as a strength when coupled with the requirement for evidence that obliged the assessor to explain his or her thinking behind selecting the item. No tool is ever

understood the same way by all users (Fotheringham, 2011) and striving to increasingly define descriptors can result in a document that is difficult to apply widely (Cross, 1998; Cross et al., 2001).

However, as one of the stated aims of the evaluation is to feedback to the study HEI [p. 63], four suggestions to alter this particular tool or training around it, are based on findings from the study. The first three relate to the tool itself and the final suggestion is to focus on training students to understand the tool and receive feedback.

Firstly, it is reported that at least some mentors have selected item 10, *needs more experience at this level* (a borderline item which is a fail after first year [see p. 55]) for students in second year that they did not want to fail [section 5.3.4.1]. It does beg the question why those mentors thought more experience was needed if the student is going to progress past the current level, but it may be that they meant the student could further improve or consolidate their skills without failing that particular placement. Although it cannot be confirmed, it seems that using item 10 in this way might be reflecting assessment of clinical skill level rather than interpersonal skill, to avoid confusion it could be removed.

Secondly, the ISP contains five other borderline items that are graded pass in first and fail in second and third years. From my own experience and some reports in this study some assessors found this a bit confusing [see sections 5.3.4.1, 5.5.1.2.1, 5.5.2.1.1]. An interesting solution proposed by Wilkinson and colleagues in a medical school could be to indicate that a student has passed, but not passed well (2011). Looking at students' achievement over the course of the programme (yearly) rather than particular course, module or placement experience they have the option for a 'conditional pass'. A conditional pass allows the student to continue but requires an action plan and a process for revising how the student is progressing. It might be useful to rename the items 8 through 13 as *conditional pass* for all years of the programme, triggering an action plan with the mentor and personal tutor to ensure the student is supported and improves. If a conditional pass were flagged up at the midpoint formative assessment, conditions could be set for success in the summative assessment at the end of the placement, or in the

following placement. The conditional pass system could trigger mechanisms identified in this study. Using the three MRTs developed it is clear that the conditional pass system would make the requirements for passing overt and clear to both mentor and student [MRT1 section 6.2.4]. An action plan is supportive of students [MRT2 section 6.2.5] and would feed-forward to the students' future performance [MRT3 section 6.2.6]. If a conditional pass were given at the midpoint in the final year, the sign-off mentor [section 7.5], would have an opportunity to review previous assessments and determine if the student would be able to achieve a pass. Getting a conditional pass in the final year could also strongly signal to a student the need to work on interpersonal skills. However a conditional pass could not be an assessment option for the summative assessment in the final placement.

Thirdly, based on the inconsistency with which the evidence was provided in the documentary analysis more explicit guidance as to what is expected from mentors could be built into the document itself, although there is a trade-off between additional guidance and making the document discouragingly long. The most recent documentation for the all-degree programme (started September 2011) has partially addressed this issue[34]. These improvements could be strengthened by a very explicit statement, such as "*provide specific evidence (e.g. examples you have witnessed or which have been reported) to support each comment selected"* coupled with a stronger statement to support development, e.g. "*briefly provide a concrete example of how the student can improve their interpersonal skills"*. As seen above, explicit instructions can improve both assessment and student performance, making it more likely the mechanisms identified in this study will be triggered.

Finally, as has been discussed [sections 2.3.1.2 and 7.5.1], training mentors and assessors in practical settings is a challenge. A further suggestion would be that students are well prepared and understand their documents. The HEI has easy

[34] In the documentation from September 2011 mentors are asked to provide a "*Summary of evidence to support the interpersonal skills comments selected"* [see p. 266], previously the requirement was to provide "*Examples of evidence to support the comments selected".* They are now specifically also asked to write "*How might the student improve their interpersonal skills?"* where previously there was a long-winded statement "*the following aspects of the student's progress and performance need further development"* which was rarely filled in, or which sometimes had comments pertaining to clinical skills

access to students and can do large and small group teaching sessions with a consistent message. At present this preparation is patchy; as M01 reported, students were frequently unaware of the requirements for assessment in practice placements [see p. 155]. The suggestion then would be to prepare the students so that they understand the tools and what is expected of them before they go into practice. Also, as suggested by Regehr and colleagues, students can be prepared to hear and take on board feedback (Regehr et al., 2011, p. 10). If the student is confident about the assessment tool and can listen to mentors' feedback, the student might also contribute to the process of assessment through dialogue and learning (Tang, 2008) rather than simply feeling judged.

## 7.9. Discussion conclusion

This section has explored the findings and theoretical models of the study in relation to the literature on practice assessment. A defence of Realistic Evaluation as a method that can handle complexity has been presented. Furthermore, key ideas such as assessment *for* learning, the gatekeeping role of the mentor, bias and subjectivity have been explored. Finally, specific suggestions for changes to the ISP and a conceptualisation of the ISP as a learning tool have been presented.

# 8. Concluding chapter: limitations, reflections and contribution to knowledge

The final section of this thesis presents a personal view on limitations of the study [section 8.1] and a critical reflection of on the experience of developing as a researcher [section 8.2]. The chapter also elucidates the contribution to knowledge [section 8.3] made by the study, including recommendations for practice and further research [sections 8.3.1 and 8.3.2].

## 8.1. Limitations

The best laid schemes o' Mice an' Men,
Gang aft agley,
An' lea'e us nought but grief an' pain,
For promis'd joy!
**Robert Burns**, *To a Mouse* (Poem, November, 1785)

No research follows a straight line from conception to implementation and this study was no different. Recruiting mentors [section 3.6.3] and collecting students' practice documents [section 3.6.5] both proved challenging, requiring revision of the planned study.

Beyond a small number of comments within practice assessment documents, the study lacks students' perspectives. Rather limited compensation was afforded through the inclusion of an unpublished study from the study HEI (Weeley et al., 2009) [section 2.4.1] which examined students' perceptions of the wider practice document.

Study limitations relating to my status as a novice researcher were raised earlier in the thesis (learning to interview 3.8.1, learning how to analyse data 4.2.1). Over the course of the study these limitations were mitigated as I gained experience and through the continued to coaching and challenging of my supervisors. Other limitations are discussed below. Section 8.1.1 addresses limitations in the literature review and the way in which it was conducted. Section 8.1.2 discusses

the limitations in recruiting research participants and section 8.1.3 focuses particularly on not including students in this study. Section 8.1.4 looks at limitations in the analysis process over the four cycles of analysis conducted in the study. Section 8.1.5 addresses the use of quotes and evidence throughout the thesis. Building on self-awareness of limitations, reflections on the process of conducting the study are outlined in section 8.2. Section 8.3 and subsections detail the contributions made to knowledge including recommendations for both practice and further research and plans for dissemination. Finally, limitations to generalisation of findings from this study are discussed in section 8.3.4.

### *8.1.1. Literature Review*

Interpersonal skills and professionalism are both difficult concepts to pin down and define and their demarcation can be challenging: perhaps overlap is inevitable. Literature on practice assessment, interpersonal skills, interpersonal skills assessment, competence, competencies, professionalism and assessment of professionalism was identified through traditional keyword searches (Polit & Hungler, 1995) of three bibliographic databases: CINAHL, ERIC and MEDLINE [section 2.1]. These databases cover a very wide range of journals and other reports, but coverage can never be complete and it is not feasible to estimate what may have been missed.

The major database searches were supplemented by searching reference lists of key articles and using a variety of search engines to seek additional materials relating to key words such as 'interpersonal skills' and 'assessment of professionalism'. Selected journals were also 'hand searched' because their scopes and foci made them rich sources of pertinent literature: these included Nursing Education Today, Medical Education, Academic Medicine and Journal of Nursing Education. These processes may have been less systematic than the main bibliographic searches, but a substantial amount of material was retrieved. Alerts to new articles came from journals' 'table of content alerts'. The reviewed literature encompassed a wide range of fields, from architecture to teacher training and an enormous array of journals. Nevertheless it is possible that key articles from journals for which I had no alerts were not identified.

### *8.1.2. Research participants*

As with all research involving volunteers, those who choose to participate do not necessarily reflect the whole (Miles & Huberman, 1994, p. 263-264). When the study was planned there was a dearth of published literature on how mentors assessed interpersonal skills in practice. In her review of research with mentors in the UK Jinks (2007) identified that most studies used postal surveys and had poor response rates. She found that mentors have extremely high workloads and, unsurprisingly, low research participation rates; regardless of how they are approached and the data collection method. In this study, despite approaching mentors at six sites through PEFs, ECs and directly through emailing, the response rate was low (about 18 contacts out of a potential pool of hundreds). The participation rate cannot be determined because the number of mentors who *received* invitations to participate is unknown.

The mentors who did participate were mostly from one trust [see Table 3, p. 83 and section 3.6.3]. This has the potential to bias findings, as suggested by M14 who said her colleagues had mostly trained and worked in the same area [p. 151], if the trust context is an influential factor. Two thirds of all the mentors (10/15) worked in clinical areas providing acute care to adults: another contextual factor which may bias findings, rendering them less applicable to mentorship in contrasting clinical settings or other fields of nursing. The homogeneity of the sample could mean that the respondents shared experiences particular to their setting, however, the bias may have been mitigated through the experience of PEFs and ECs who were more representative of a variety of fields of nursing and clinical areas.

The majority of mentors (11/15) who agreed to participate identified themselves as particularly interested in mentoring, supporting students and in education (two were pursuing further study in clinical education). The self-selecting group interviewed for this study cannot be considered representative of the wider population of mentors, but they all reported on other colleagues experiences and challenges as well as their own. Though more interested and aware of students, these mentors were not themselves borderline [see p. 112] but could relate to struggling colleagues and the wider experience of mentoring. None of the

participating mentors were actively struggling with a challenging student during the study, although most recounted experiences of having done so, or vicarious experiences gleaned from other mentors. Though, as might be expected, none of the participating mentors were unengaged with students. In this study, data for CMO2, which focuses on mitigating mentor weaknesses, came from junior and inexperienced mentors who seemed to have self-awareness about their limitations as mentors. Some evidence of disengaged or poor mentorship could be seen in the comments in the documentary analysis [section 3.8.2]; however, from documents alone it was impossible to know what was said, or what the context of each assessment was. It is possible that the mentors who participated were using the ISP in a different way than those who did not, however, the suggestions for change [section 7.8] and the idea of the ISP as a learning tool [section 7.7] attempt to include mentors for whom mechanisms of support were not triggered by the ISP.

Another possible limitation is that participating ECs were former colleagues from sites A and B [see section 3.6.2] and the potential impact of interviews with ECs from site C can only be a matter of speculation. While participating ECs represented different sites (A and B) and aspects of both community and hospital nursing, they reported similar issues around supporting students and mentors [see discussion of data saturation 3.6.6], which increased confidence in the study findings. Nevertheless it is possible ECs from site C could have added another dimension or added depth to the study.

### *8.1.3. Not including students*

The biggest limitation to this study, and to the evidence supporting the CMOs and MRTs, is the lack of student perspectives. The focus of the study was how the tool is actually used in practice and through interview and documentary analysis this has been tapped into. However, the outcome that the student can change their interpersonal skills or can challenge unfair assessments [section 5.5.3] has been verified only second hand through participants reporting on students whose actions they witnessed. Some self-assessment comments in the documentary analysis attest to the possibility of student challenges, however, the assertion that students can learn from the ISP [sections 5.5.3.2, 6.2.6 and 7.7] does not come directly from the students' voices.

Students views of being assessed have been studied in many professions and countries (Neary, 1997b; Calman et al., 2002; Diekelmann & McGregor, 2003; Guilkers et al., 2006; Webb & Shakespeare, 2008; Parker, 2010) and issues of process and power have been identified. Further study on the perspective of students being assessed by the ISP would be valuable: including an investigation into whether feedback is constructive and supports development, or fuels lower self-esteem [see recommendations for research section 8.3.2].

### *8.1.4. Analysis*

Although analysis was concurrent with data collection and guided later interviews [see Methodology 3.9] some of the major insights did not happen until further in the abstraction process [see Data Analysis 4.2.2] and could not be checked and challenged through further data collection. For instance, the discrepancy between written and verbal feedback to students [section 5.2.4] could also be further researched. Another insight was the impact of field of nursing—particularly the Mental Health field [section 5.4.1.2]—on interpersonal skills assessment which could be further investigated [see section 8.3.2 on further research].

Realistic Evaluation provides no specific guidance on how to uncover CMOs or analyse data, leaving researchers to seek guidance elsewhere (possibly at the risk of overlooking conflicts between the philosophical heritage and epistemology of Realistic Evaluation). This study attempted to overcome this limitation by seeking guidance from the literature. The approach to data collection and analysis was influenced by Interpretive Description (Thorne et al., 1997) [see Methodology 3.9.1] in which the analytic framework acknowledges the researcher's pre-existing knowledge and ideas (in this study called 'sensitising concepts' [section 3.10.1]). Interpretive Description fits in with the Critical Realist epistemology that encompasses individual interpretation alongside the 'real' [section 3.2]. As Thorne and colleagues say:

> *"The qualitative nursing research approach suggested here is grounded in an interpretive orientation that acknowledges the constructed and contextual nature of much of the health–illness experience, yet also allows for shared realities"* (Thorne et al., 1997, p. 172)

Further guidance was provided by the example of Byng and colleagues Realistic

Evaluation study reported in two papers (2005; 2008).

Like interviewing [section 3.8.1], data analysis is a skill which developed over the course of the study. My documentation or 'memo-ing' (Burnard, 1991; Madill et al., 2000) of insights and developments was not as rigorous as it could have been, despite the advice of my supervisors. I found that while immersed in analysis, I took insights for granted or thought they seemed so important that they could be remembered and documented later. However, 'later' the process was difficult to recall. Therefore the 'audit trail' of thought processes is disorganised and incomplete. However the CMOs and concepts have been challenged thoroughly in the data (sections 5.2.4, 5.3.4, 5.4.4 and 5.5.4): mitigating, so far as is possible, my earlier lack of expertise and rigour.

### *8.1.5. Quoting and evidence*

The purpose and practice of selecting quotes for presentation is a source of debate in the qualitative research community. Corden and Sainsbury (2004; 2006) studied the reasons that social science researchers gave for providing quotes in reports. Researchers' rationales varied widely, and some provided simultaneous, multiple reasons: amongst them, providing evidence to support data analysis (to support trustworthiness of analysis), to give the participants a voice of their own, and to illustrate concepts from the analysis. Including verbatim quotes was an important part of this qualitative research report for all of those reasons, but in common with many researchers (Corden & Sainsbury, 2004), the selection of quotes has been uneven. However, as Ahern suggests (Ahern, 1999) in her 'Ten Tips for Reflexive Bracketing', there are reasons why some 'voices' are louder than others. In this study PEF03 was particularly critical of the ISP and voiced many challenges to mechanisms [section4.1.1, p. 99]. Challenging mechanisms is an important part of Realistic Evaluation [5.1.1.1] and her comments therefore receive more attention. Participants M01 and M04 were articulate and therefore quotable, they did not unduly sway the analysis, they simply stated ideas more succinctly and so their comments were used for illustration. The aim is that the quotes in the thesis allow the reader to judge for themselves the credibility of the abstracted concepts.

## 8.2. Reflections

During the course of this doctorate I changed jobs from the study HEI to work in a clinical area, I had a second child and moved to a new country [see Figure 10, p. 94 for timeline]. These radical changes have had an impact on many aspects of the study:

- **Data collection**: Moving away from the HEI enabled me to be closer to mentors and gave me more flexibility to conduct interviews but may also be the reason why those that responded were mostly from my own hospital setting
- **Data analysis**: Initial interviews of PEFs had begun while I was employed as a lecturer at the study HEI. My concerns and impressions of the mentor and student experience shifted subtly after I became a practice development nurse in one of the study trusts. However, as noted above [section 8.1] my memo-ing and reflective writing was not consistent or rich enough to capture these subtleties.
- **Writing up**: the sleep deprivation and limited attention span that accompany a new child's arrival have formed the backdrop of the synthesis of the Data Analysis, Literature Review and presentation of the Findings. I have striven for a coherent picture of CMOs and theories behind assessment of interpersonal skills but may well have fallen short. On the plus side, stepping away from the study for a period of maternity leave gave me some distance from which to critique and develop the study upon my return. I also developed a drive to complete the study and some momentum to writing up.

I am not by nature a reflective writer or journal keeper; I am a better thinker in discussion and conversation. Throughout this study I have tried to be a reflexive researcher in the third sense that Freshwater and Rolfe (Freshwater & Rolfe, 2001, p. 531) describe as practical reflection "*[⋯] reflection-in-action, in which practice [in this case practice of research] is reflected on and modified as it is happening.*" Like the mentors assessing interpersonal skills who are open to charges of bias and subjectivity from their students, I can only hope that I have provided sufficient evidence and examples to support my assertions and have produced an accessible and rigorous piece of work.

## 8.3. Contributions to knowledge and the significance of theoretical models

Contribution to knowledge is the purpose of doctoral study and the thesis report is the main way of delivering this contribution. This section will review the importance of the research question, discuss the significance of the findings and their implications for practice and theory (further research in section 8.3.2), and summarise the limitations to generalisation discussed above [in section 8.3.4].

The primary research question [sections 2.6 and 7.2] asked how a particular tool, the ISP, already in use at several HEIs in the UK was used in a particular pre-registration nursing programme in England to assess interpersonal skills in practice. Guided by the methodology of Realistic Evaluation the secondary questions were about context, mechanisms at work in using the tool and outcomes of using it [see Discussion sections 7.2.1, 7.2.2 and 7.2.3]. These questions were important because existing literature identified that assessment of interpersonal skills is problematic [see chapter 2]. Mentors find it hard to provide useful developmental feedback on students' interpersonal skills [section 2.3.2.1]. Assessment tools developed and tested in several other contexts have limitations [section 2.3.3] and are not well-suited for frequent use by a large population of mentors, with diverse levels of expertise and interest, with many conflicting demands upon their time, who work in diverse but almost always very busy clinical settings [sections 2.3.1.2 and 5.4.1.1]. A simple and effective way to provide students with feedback on their interpersonal skills (and a way to document their levels of achievement) would meet a significant gap in assessment practice: hence the embedded use of the ISP is an important topic for research. This study developed theorised mechanisms about how assessments can be designed to facilitate interpersonal skills despite these challenges [section 6.2 for MRTs].

One criticism of Realistic evaluation is that it is too linear and generates context → mechanism → outcome configurations [see section 7.3]. However, in contrast, one of the theoretical models developed in this study, the 'spiral of raised awareness' [see section 6.1] is a way of conceptualising the complex interactions *between* context, mechanisms and outcomes. This model contributes to the literature on Realistic Evaluation, demonstrating that non-linear models can be developed and

that the approach can be used to study complex systems. Although in their research on policy implementation at a national level Pedersen and Rieper (2008) had previously suggested that Realistic Evaluation could be used evaluate complex and multifaceted interventions, they had not demonstrated the complex interplay between context, mechanisms and outcomes as expressed by the 'spiral of raised awareness' [section 6.1]. The 'spiral of raised awareness' also contributes to the literature on 'scaffolding' as a technique to support students while they are challenged to extend beyond their comfort zone and they develop and hone their interpersonal skills student learning [section 6.1.1].

Though the study was conducted in a particular HEI and programme, data analysis and abstraction from the findings led to the development of three middle-range theories [MRTs] [sections 6.2 and 7.2.4] These abstract relevant features of the context-specific data to a level which can inform the design of tools to assess interpersonal skills beyond pre-registration nursing in the UK. As Wong and colleagues (2012) state:

> *"Realist research does not prove or disprove particular middle-range theories. Rather, it produces explanations which: (i) plausibly account for observed patterns in the data; (ii) accommodate (as far as possible) the range of contingencies and exceptions found, and (iii) fit closely and build on current best understandings of the field. A good realist theory is open for further testing and iterative refinement against empirical data."* (Wong et al., 2012, p. 93)

The MRTs could guide other professions' assessment strategies for developing and assessing students' interpersonal skills. Though the ISP itself has been adapted to a variety of settings, and could be adapted for many more, the MRTs propose that through ensuring that certain criteria are met (explicitness, documentation and clarity of feedback, see section 7.2.4), educators from a spectrum of professions could incorporate an element of interpersonal skills assessment into their own (existing) practice assessments.

### *8.3.1. Recommendations for practice and education*

This study has identified several mechanisms by which a tool to measure interpersonal skills facilitated their overt assessment and allowed students a chance to change their interpersonal skills or to challenge the assessment. To date, a focus of the literature around assessment of professionalism, interpersonal skills and 'non-technical skills' has been on developing tools specific to particular

specialisms and settings (Regehr et al., 2011). The three middle range theories suggest that emphasis should not be on new tool development; what is needed is clarity and documentation so that the content of the assessment can be understood and acted upon. Assessment that is implied by and integrated into broader practice assessment documents may be sufficient to meet the requirements of the accrediting bodies or academics involved with external examination of programmes and courses, but can impede the effective assessment of interpersonal skills. Furthermore, the reality for many professions is that it is difficult to train all assessors to use particular assessment tools [see section 7.5.1] and give appropriate feedback; therefore the ISP (or something similar) could facilitate this process. The ISP is not necessarily the best tool for all professions in all places, but the key findings suggest that any tool used to assess interpersonal skills in professional education programmes that contain an assessed practice component should attempt to:

1) Make requirements about interpersonal skills assessment explicit to assessors and learners [MRT 1 section 6.2.4]
2) Consider ways in which the documentation can support assessors both practically and emotionally to undertake what are often perceived as difficult and subjective assessments [MRT 2 section 6.2.5]
3) Make feedback as clear and explicit as possible so learners can learn from it and develop their interpersonal skills over the course of their programme [MRT 3 section 6.2.6]

Another suggestion arsing from this study is that for nurse education in particular, mentor preparation should focus on skills around giving feedback and evaluating students, no matter what tools are in use [section 7.5.1]. Furthermore, as so many nurses go on to become mentors, the results from research on feedback and assessment (see 7.4.1 and the next section) might usefully form a strand of pre-registration nursing education.

### *8.3.2. Recommendations for research*

This study focused on mentors' perspectives on interpersonal skills assessment using the ISP, which extended previous research including other aspects of the mentor perspective on interpersonal skills assessment [section 2.3.2.1].

Complementary research on students' perspectives of the ISP approach would be helpful to fill in the gap noted in the limitations section 8.1.3 and, more widely, to extend knowledge of the student experience of interpersonal skills assessment. Concrete research on this aspect could address the reported fears around assessing aspects of student performance perceived to be personal and potentially difficult for students [sections Literature Review 2.3.2 and Findings 5.3.2.1]. For example, further research could be undertaken from the student perspective of taking on board feedback and improving interpersonal skills, or (hopefully rarely) challenging unfair assessments. The diverse experiences of students doing well and those struggling in practice were not captured in this study. Prospective longitudinal research following one or more cohorts of students over the course of the programme would fill this gap and could contribute to the identification of further mechanisms to support the overt and effective assessment of interpersonal skills.

Observational research on mentors' feedback and delivery of assessments using the ISP would also be valuable. As noted in section 8.1.4 further research on the relationship between field of nursing practice and assessment of interpersonal skills could be conducted, extending the body of educational and assessment research focused on practice assessment.

Finally, the concept of the 'borderline mentor' articulated by participants in the study [see section 7.2.1, p. 195 for a summary] could be investigated. Further research into the characteristics of 'borderline mentors' and how to support them, could strengthen practice assessment in areas beyond interpersonal skills assessment.

### *8.3.3. Dissemination*

The two-fold purpose of this study was to generate new knowledge and to feedback to the study HEI [see section 3.1]. New knowledge on implementation of the Realistic Evaluation approach and on the assessment of interpersonal skills will be disseminated through presentations at relevant meetings such as the health

science education conferences[35], publication in academic journals[36] and work with the local university and higher health science education networks in Antwerp, Belgium. The final plan for dissemination is through electronic publication of the thesis. Electronic publication of dissertations has enabled me to find some key content (McGregor, 1996; Stokes, 2005; Finch, 2009; Hanlon, 2009; Finn, 2010) and methodology references (Gilmour, 2008; Thistleton, 2008; Hogg, 2010). This thesis report can be a resource for others in a similar way.

Copies of the thesis alongside a brief summary of the findings and recommendations will be sent to key colleagues (who have been aware of and involved with the study) at the study HEI and related clinical areas. Similarly, a copy and summary will be sent to the PEFs through their manager. In this way, the findings and recommendations can be disseminated and a two-way channel of communication will be opened for further discussion or exploration with the study HEI and related clinical sites. Throughout the study period, key notions, such as the importance of keeping the requirement for evidence have been fed back to colleagues at the study HEI, in order that documents for the next five-year curriculum were not altered to their detriment.

### *8.3.4. Limitations to generalisation*

This study was conducted at one HEI in England in a pre-registration nursing programme. As has been outlined in the introduction [section 1.3] and in Appendix B, the HEI had recently undergone a large change as two institutions had converged, each with their own practice assessment histories. Furthermore, respondents can only ever talk about their own experiences, even if like PEFs and ECs they have a broader view due to the nature of the role. These limitations are common to most research; it took place at a particular time, in a particular place with a particular group of people. In this thesis I have attempted to provide enough detail as to place, methodology, method and analysis for the reader to infer relevance to their own context (Slevin & Sines, 1999; Graneheim & Lundman,

[35] NET (Networking for Education and Health) conference next in Cambridge, UK, 3-5 September 2013, AMEE the Association for Medical Education Europe conference next in Prague, Czech Republic 24-28 August 2013. Applications in progress.

[36] A paper is in press: Meier, K.M., Parker, P. & Freeth, D. 2013. Mechanisms that support the assessment of interpersonal skills: A Realistic Evaluation of the Interpersonal Skills Profile in pre-registration nursing students. *Journal of Practice Teaching and Learning*

2004). However, Realistic Evaluation is designed to assist in generalising research in that the approach calls for abstraction of data into Context, Mechanisms and Outcomes allowing the reader to determine what might be transferred [see section 3.3.3].

Further abstraction led to four conceptual models, the spiral [section 6.1] and three MRTs [section 6.2], which allow the possibility of theoretical generalisation (Heathfield, 2001; Byng et al., 2005; Wong et al., 2012). These increase the scope for transferability. However in the process of abstracting, detail is inevitably lost; thus the conceptual models do not provide a blueprint for how to implement a strategy for interpersonal skills assessment but suggest principles and provide general guidance.

## 8.4. Conclusion

Sometimes the lights all shining on me
Other times I can barely see
Lately it occurs to me
What a long strange trip it's been
**Robert Hunter**, *Truckin'*, (chorus of a song, 1970)

Using a Realistic Evaluation approach this study aimed to explore how a tool, the ISP was used in practice to assess interpersonal skills. Particular contexts were explored and outcomes identified [section 2.6]. The abstraction of the mechanisms led to three simple middle range theories. Realistic Evaluation is a pragmatic research approach that nonetheless has a philosophical grounding including a belief that findings from studies such of these belong to the transitive or changeable realm of reality [see Figure 5, p. 64] and as such will ultimately be superseded. Building on work that has gone on before me through the Literature Review and identification of 'sensitising concepts' [section 3.10.1], the aim of this study was to identify some ways in which interpersonal skills might effectively be assessed in the complex and challenging context of work based placements for professional learning. My hope is that these modest recommendations will underpin the work of others and further the development of theory around assessing interpersonal skills in a practical setting

# 9. References


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# 10. Appendix A

**LEVELS OF ACHIEVEMENT IN THE INTERPERSONAL SKILLS PROFILE**

This Interpersonal Skills Profile is an essential element of the Practice Assessment and all students must achieve a Pass grade if they are to progress with the course. However, we recognise that there needs to be an opportunity to progress and that student's early in the course should not be expected to show the same maturity of approach as students nearing qualification.

Please select FIVE comments from the list below which most closely describe the performance of the student.

| | | |
|---|---|---|
| 1. | (F) | Behaves in an unprofessional manner. |
| 2. | (F) | Unsafe to practice. |
| 3. | (F) | Displays a negative attitude. |
| 4. | (F) | Blames circumstances for difficulties encountered. |
| 5. | (F) | Appears to lack motivation. |
| 6. | (F) | Does not define own learning needs. |
| 7. | (F) | Lacks self-awareness and the effect of behaviour on others. |
| 8. | (F/P) | Needs to take responsibility appropriate for this level. |
| 9. | (F/P) | Lack of confidence inhibits effective performance. |
| 10. | (F/P) | Needs more experience at this level. |
| 11. | (F/P) | Reacts adversely to constructive criticism. |
| 12. | (F/P) | Slow to settle. |
| 13. | (F/P) | Lacks maturity. |
| 14. | (P) | Needs to be more assertive. |
| 15. | (P) | Could have made more use of available resources. |
| 16. | (P) | Has not achieved full potential. |
| 17. | (P) | Willing to try. |
| 18. | (P) | Has developed in confidence. |
| 19. | (P) | Skills will develop with practice. |
| 20. | (P) | Assimilates new information. |
| 21. | (P) | Accepts appropriate responsibility. |
| 22. | (P) | Fits well into the team. |
| 23. | (P) | Has a pleasant and approachable manner. |
| 24. | (P) | Displays a mature attitude. |
| 25. | (P) | Well-motivated and adaptable. |
| 26. | (P/G) | Is able to reflect on outcomes. |
| 27. | (P/G) | Identifies own learning needs. |
| 28. | (P/G) | Has made a useful contribution to the work of the team. |
| 29. | (P/G) | Shows a good understanding of the concepts of nursing/midwifery. |
| 30. | (G) | Displays confidence. |
| 31. | (G) | Analytical in approach, drawing from a wide range of sources. |
| 32. | (G) | Offers informed and considered opinions. |
| 33. | (G) | Realistically evaluates performance. |
| 34. | (G/E) | Capable of informed decision-making. |
| 35. | (G/E) | Shows a mature understanding. |
| 36. | (G/E) | Valued team member who has gained respect. |
| 37. | (E) | Innovative, develops fresh ideas. |
| 38. | (E) | Consistently works at a higher level than expected. |
| 39. | (E) | An excellent performer in all areas. |

**Key:** The Profile affords a number of levels of achievement, which will be used in the following manner:

| | |
|---|---|
| Fail (F) | This grade applies in all three years of the course. The inclusion of this grade in the student's profile constitutes a Fail for that module. |
| Fail/Pass (F/P) | This grade denotes a Pass in Year 1, but a Fail in Years 2 and 3. |
| Pass (P) | This grade denotes a Pass in all years of the course. |
| Pass/Good (P/G) | This grade denotes a Good profile in Year 1 and a Pass in Years 2 and 3. |
| Good(G) | This grade denotes a Good profile in all years of the course. |
| Good/Excellent (G/E) | This grade denotes an Excellent profile in Year 1 and a Good profile in Years 2 and 3. |
| Excellent (E) | This grade denotes an Excellent profile in all years of the course. |

**Source: University of Northampton**

**FORMATIVE ASSESSMENT OF INTERPERSONAL SKILLS PROFILE (Mid point of placement)**
**MODULE 11: Preparation for Professional Practice**

Write in the boxes below the numbers of the interpersonal skills comments that have been selected from page 25.

| No: | No: | No: | No: | No: | Mentor's signature | Date |
|---|---|---|---|---|---|---|
| | | | | | | |

**Mentor Assessment:**
**Summary of evidence to support the interpersonal skills comments selected:**
*
**How might the student improve their interpersonal skills?**
*
**Student reflection on above comments**

*
**Mentor signature / Date**…….....

**Student signature / Date**…….

* Spaces minimised to fit onto one page, the document reformatted to fit the requirement of the thesis submission. A large text box is provided for the assessor's comments and for student reflections.

# 11. Appendix B

The practice assessment document in use at the study HEI evolved over the study period and will continue to do so in response to feedback from mentors, personal tutors and students. In order to give readers a sense of the context of how students were being evaluated in practice during the study period, this appendix outlines the main components of the documents as introduced in 2007 and the major changes made before the end of interviewing and document collection in 2010 [see Figure 9 on p. 76 for the study design].

## 11.1. The Interpersonal Skills Profile

The Interpersonal Skills Profile (ISP) was included in every practice assessment document throughout pre-registration nursing training in all years and fields of nursing. The ISP was adapted from a tool developed in Northampton for occupational therapy (OT) students (Knight, 1998; Knight, 2003). The original OT ISP was fine graded from A through F and contributed to students' degree classifications. The study HEI adapted the OT ISP for use with nursing students in the HEI's local contexts. Firstly, the grading was simplified to four levels: fail, pass good or excellent [see Appendix A]. As shown on p. 255, the modified ISP maintained the dual graded items: for instance items eight to 13, as with Knight's original ISP, were sufficient for students' to pass in first year, but resulted in a fail grade for students in years two and three. Similarly, items 26 to 29 were graded 'good' for first year students, but 'pass' for second and third year students. Finally, items 34 to 36 were graded 'excellent' in first year and 'good' in years two and three. The system of dual grading acknowledged increased expectations as students progressed through the course. An innovation from the study HEI was to provide a separate page each for formative and summative selections along with half a side of A4 paper for comments. Thus in this study mentors were asked to select 5 items that best described the student's performance and to provide evidence to support the items they chose. Students were also asked to briefly document their own self-assessment at both the formative and summative assessments.

## 11.2. Other aspects of the evolving practice assessment document

The practice assessment document and were composed of a variety of information sheets and other assessment tools. Internal evaluation revealed positive reactions to the HEI's practice assessment documents as a whole (Weeley et al., 2009) [discussed in section 2.4.1], a theme which recurred in this study:

> P28: PEF06 (48:48)
> PEF06: they like the way it's all for example in one book, you know it's quite handy, it's well laid out from the point of view of its progression through the placement, the initial interview, the formative, the summative, so they enjoy that, the information is all there, it's in the book, it's like a one stop shop which I think they appreciate.

As PEF06 reported, the practice assessment documents were comprehensive, enabling mentors to assess several aspects of students' practice.

Each assessment document started with a group of documents orienting students and mentors as to what was expected in the placement area. There was a brief introduction to practice assessment and an outline of both mentor and student responsibilities. A list of clinical skills the students were to undertake (in practice or in the skills labs at the HEI) in each year was included starting in September 2009. Lists of the proficiencies required by the NMC to enter into field (to continue into second year) or join the register (to qualify after year three) were also provided. A sheet to record the initial meeting between student and mentor was provided in an attempt to ensure that the student was oriented to the area and had met their mentor within the first week of placement.

To support mentors in documenting learning outcomes and student achievements, the HEI suggests using learning contracts. An example learning contract modelling what was expected of mentors and students and addressing both technical skills, such as care of the patient receiving an IV infusion, and knowledge skills, such as awareness of social policies influencing practice was included. A blank learning contract followed the example learning contract. However, little guidance on how the learning contract should have been used and or on the consequences of failing to achieve an item in the learning contract was provided.

To encourage and to document interprofessional working there were two pages for feedback from members of other professions. Although there was space for

seven comments, this feedback was not mandatory and it is unclear how many comments students were required to collect. On the final summative page mentors were asked to verify that students had spent half a day with a member of the interprofessional team or with someone outside the practice setting but it is not clear if failing to do so would cause the student to fail the module.

The NMC published the Essential Cluster Skills (ECS) in 2007 [see p. 17] and the HEI developed checklists of skills that should be achieved in each placement. These have also evolved over time with the 2011 version of the document providing less detail and more explicit instructions on how to achieve the criteria, for instance *"Work in partnership with patients enabling them to make informed choices about their planned care"* has been replaced by *"Reflect on 3 separate occasions where you observed your mentor working in partnership with patients enabling them to make informed choices about their planned care"*.

Finally each practice assessment document included an attendance diary (to be signed by clinical staff each shift that the student worked). This was photocopied by the student and sent to the HEI's placement coordinators to keep track of attendance and absence in line with the NMC's requirement to spend at least 2,300 hours in practice over three years (Nursing and Midwifery Council, 2008a).

The physical structure of the practice assessment book evolved over the course of the data collection period. When introduced in September 2007 there was one practice book per session (six months of the year) however, starting in March 2008 this was divided to reflect the two modules in each session [see p. 20 for detail on the course structure]. The ECS were also separated with half to be achieved in each module. In order to spread five ECS evenly across the modules, ECS 1 (care, compassion and communication) was split into two parts, care and compassion in the first module of the session and communication in the second. By February 2010 some mentors contributing to this study were still unaware of the changes. For example, M11 expressed surprise that after signing one booklet the student 'appeared' in the placement with another to complete. She was unaware of the modular structure of the course and thought the second module document was

a repeat of first module document. Not having the two documents side by side she had not noticed that the student was being assessed on different ECS.

Session 3, the first half of second year in the Adult nursing field, was exceptional and was assessed with a single practice document. In Session 3 the focus was on community nursing. Students were placed with a district nurse (seeing him or her for 50% the time) and went out to shorter placements (of one or two weeks) in a variety of outpatient clinics and services related to the community[37]. In the Session 3 Adult field practice assessment document, therefore, there is a page for the mentor from each short placement to comment on the student's performance. From September 2007 to September 2009 this was a freetext box with three questions around 1) aspects of student performance to be commended, 2) aspects for development (a learning contract is suggested) and 3) professional behaviour. After September 2009 the mentor for each short placement was required to assess using the ISP, choosing five statements and providing evidence for each. There were still two free-text areas for mentors to comment on areas for commendation or development. Thus, over the six months the Adult field student was assessed at least seven times using the ISP. Session 3 was the only period of the students' training during which mentors could see what others had written about the same student. However, this change occurred in cohorts after those recruited for the documentary analysis in this study. An interesting line of further study would be to look at ISP assessments that were completed in short placements and where the assessors could see what items other assessors had selected.

## 11.3. Practice assessment document conclusion

The practice assessment documents are complex and composed of various sections of which, the ISP is but one. There have been a variety of changes to the way the documents are presented and some rewording of items over the course of the study. It seems likely this will continue into the future. This appendix provides a more detailed picture of the practice assessment document as part of the context of the ISP in use during the study period.

[37] In the practice development role, my place of work provided one of these short placements where students came for one week.

## 11.4. Sites A/B documents

Sites A/B part 2 (first year) 'Verification of Professional Development'

| **Does the student:** | **Enter: Y =Yes N = No** | **Formative** | **Formative** | **Summative** |
|---|---|---|---|---|
| 1. Recognise and acknowledge the limitations of his/her own abilities as a student of nursing? | **Student** | | | |
| | **Mentor** | | | |
| 2. Recognise situations that require referral to a registered practitioner? | **Student** | | | |
| | **Mentor** | | | |
| 3. Accept responsibility for own actions and decisions? | **Student** | | | |
| | **Mentor** | | | |
| 4. Respect the individual's right to confidentiality? | **Student** | | | |
| | **Mentor** | | | |
| 5. Identify ethical issues in everyday practice? | **Student** | | | |
| | **Mentor** | | | |
| 6. Identify key issues in health and safety legislation relevant to their practice? | **Student** | | | |
| | **Mentor** | | | |
| 7. Demonstrate fairness and sensitivity to the needs of individuals? | **Student** | | | |
| | **Mentor** | | | |
| 8. Take responsibility for own learning? | **Student** | | | |
| | **Mentor** | | | |
| 9. Select relevant evidence to support care actions? | **Student** | | | |
| | **Mentor** | | | |
| 10. Relate 2 clauses of the Nursing and Midwifery Council Code of Professional Conduct to nursing care delivery? | **Student** | | | |
| | **Mentor** | | | |

Sites A/B part 4 (final year) 'Verification of Professional Development'

| **Does the student:** | **Enter: Y =Yes N = No** | **Formative** | **Formative** | **Summative** |
|---|---|---|---|---|
| 1. Act in accordance with the NMC Code of professional conduct? | **Student** | | | |
| | **Mentor** | | | |
| 2. Consult with a registered nurse when appropriate to do so? | **Student** | | | |
| | **Mentor** | | | |
| 3. Work collaboratively as a member of the multidisciplinary care team? | **Student** | | | |
| | **Mentor** | | | |
| 4. Identify unsafe practice and respond appropriately? | **Student** | | | |
| | **Mentor** | | | |
| 5. Practice in accordance with key legislation, national and local policies? | **Student** | | | |
| | **Mentor** | | | |
| 6. Promote the interests and well-being of the patient/client at all times? | **Student** | | | |
| | **Mentor** | | | |
| 7. Ensure patient/client confidentiality? | **Student** | | | |
| | **Mentor** | | | |
| 8. Practice with regard for the rights, customs and beliefs of individuals? | **Student** | | | |
| | **Mentor** | | | |
| 9. Support peers and colleagues? | **Student** | | | |
| | **Mentor** | | | |
| 10. Identify and act upon any deficit in their knowledge or skills likely to affect client care? | **Student** | | | |
| | **Mentor** | | | |

Appendix B: HEI assessment strategy and previous documents

Sites A/B part 5 (final placement) 'Verification of Professional Development'

| **Does the student:** | **Enter:**<br>**Y =Yes**<br>**N = No** | **Formative** | **Formative** | **Summative** |
|---|---|---|---|---|
| 1. Manage own practice, and that of others in accordance with the NMC Code of professional conduct? | **Student** | | | |
| | **Mentor** | | | |
| 2. Recognise own abilities and limitations, acting on any deficit in knowledge or skills likely to affect client care? | **Student** | | | |
| | **Mentor** | | | |
| 3. Employ effective inter-professional working practices which respect and utilise contributions of the multidisciplinary team? | **Student** | | | |
| | **Mentor** | | | |
| 4. Demonstrate sound clinical judgement? | **Student** | | | |
| | **Mentor** | | | |
| 5. Practice in accordance with key legislation, national and local policies? | **Student** | | | |
| | **Mentor** | | | |
| 6. Create and use opportunities to promote the health of clients and groups? | **Student** | | | |
| | **Mentor** | | | |
| 7. Practice in accordance with an ethical and legal framework which ensures the primacy of client interest and well-being? | **Student** | | | |
| | **Mentor** | | | |
| 8. Practice with regard for the rights, customs and beliefs of individuals, within a framework of informed consent? | **Student** | | | |
| | **Mentor** | | | |
| 9. Delegate duties to others as appropriate, ensuring they are supervised and monitored? | **Student** | | | |
| | **Mentor** | | | |
| 10. Evaluate and document the outcomes of nursing and other interventions? | **Student** | | | |
| | **Mentor** | | | |

## 11.5. Site C practice assessment documents

Appendix B: HEI assessment strategy and previous documents

Relevant sections of the NMC Standards of Proficiency for Entry to the Register

**NMC Standards of Proficiency for Entry to the Register – First Level Nurses**

**A. Professional/Ethical Practice**

| |
|---|
| **1. Manage oneself, one's practice, and that of others, in accordance with the NMC Code of Professional Conduct: standards for conduct, performance and ethics, recognising one's own abilities and limitations.** |
| a) Practice in accordance with The NMC code of professional conduct: standards for conduct, performance and ethics<br>b) Use professional standards of practice to self-assess performance<br>c) Consult with a registered nurse when nursing care requires expertise beyond one's own current scope of competence<br>d) Consult other health care professionals when individual or group needs fall outside the scope of nursing practice<br>e) Identify unsafe practice and respond appropriately to ensure a safe outcome<br>a) Manage the delivery of care services within the sphere of one's own accountability. |
| **2. Practise in accordance with an ethical and legal framework which ensures the primacy of patient and client interest and well-being and respects confidentiality.** |
| a) Demonstrate knowledge of legislation and health and social policy relevant to nursing practice<br>b) Ensure the confidentiality and security of written and verbal information acquired in a professional capacity<br>c) Demonstrate knowledge of contemporary ethical issues and their impact on nursing and health care<br>d) Manage the complexities arising from ethical and legal dilemmas<br>e) Act appropriately when seeking access to caring for patients and clients in their own homes. |
| **3. Practise in a fair and anti-discriminatory way, acknowledging the difference in beliefs and cultural practices of individuals or groups**. |
| a) Maintain, support and acknowledge the rights of individuals or groups in the health care setting<br>b) Act to ensure that the rights of individuals and groups are not compromised<br>c) Respect the values, customs and beliefs of individuals and groups<br>d) Provide care, which demonstrates sensitivity to the diversity of patients and clients. |

**D. Personal/Professional Development**

| |
|---|
| **16. Demonstrate a commitment to the need for continuing professional development and personal supervision activities in order to enhance knowledge, skills, values and attitudes needed for safe and effective nursing practice.** |
| a) Identify one's own professional development needs by engaging in activities such as reflection in and on, practice and lifelong learning<br>b) Develop a personal development plan which takes into account personal, professional and organisational needs<br>c) Share experiences with colleagues and patients and clients in order to identify the additional knowledge and skills needed to manage unfamiliar or professionally challenging situations<br>d) Take action to meet any identified knowledge and skills deficit likely to affect the delivery of care within the current sphere of practice. |
| **17. Enhance the professional development and safe practice of others through peer support, leadership, supervision and teaching**. |
| a) Contribute to creating a climate conducive to learning<br>b) Contribute to the learning experiences and development of others by facilitating the mutual sharing knowledge and experience<br>c) Demonstrate effective leadership in the establishment and maintenance of safe nursing practise. |

## Site C (same for each module) END OF SESSION REPORT – STUDENT ASSESSMENT

(It is recommended that you keep a copy of this for your Professional Profile).

| |
|---|
| 1. STUDENT*'S OWN ASSESSMENT OF PROGRESS :-* **You should give evidence of the ways in which you have met the aims identified in your learning contract and place a copy of this evidence in your personal profile).** |
| 2. |
| 3. [space for writing reduced for inclusion in the appendix] |
| **4.** |

## END OF SESSION REPORT – MENTOR'S REPORT.

| |
|---|
| **5. TO BE COMPLETED BY MENTOR** |
| 6. 1.The following aspects of the student*'s progress and performance are to be commended:-* |
| 7. |
| 8. [spaces for writing reduced for inclusion in the appendix] |
| 9. |
| 10. |
| 11. 2. Have issues and concerns identified *during the community placements been satisfactorily addressed? (If 'No', specific details must be entered under section 3 below.)* |
| 12. |
| 13. |
| 14. |
| 15. 3.The following aspects of the student*'s progress and performance still need development:-* |
| 16. |
| 17. |
| 18. |
| 19. |
| 20. 4.In the event of failure*, please state reasons below:* |
| 21. |
| 22. |
| 23. |
| 24. |
| 25. Mentor*'s Signature: ……..…….* Name: (please print) *……* Date: *……..…..* |
| 26. |
| 27. Student*'s Signature: ……..…* Name: (please print) *……..*Date: *……..* |
| 28. |
| 29. IBL Facilitator*'s signature: ……* Name: (please print) *……* Date: *……..* |

# 12. Appendix C

**PROFESSIONALISM MINI-EVALUATION EXERCISE**

Evaluator:_____
Student/Resident:_____

Level: (please check) ⎕ **3rd yr** ⎕ **4th yr** ⎕ **res 1** ⎕ **res 2** ⎕ **res 3** ⎕ **res 4** ⎕ **res 5**
Setting: Patient Related: ⎕ **Patient Present** ⎕ **Patient Not Present**
⎕ **Ward** ⎕ **Clinic** ⎕ **OR** ⎕ **ER**
Non Patient Related: ⎕ **ie – general teaching, small group teaching, etc.**

| | N/A | UN | BEL | MET | EXC |
|---|---|---|---|---|---|
| Listened actively to patient | | | | | |
| Showed interest in patient as a person | | | | | |
| Recognized and met patient needs | | | | | |
| Extended his/herself to meet patient needs | | | | | |
| Ensured continuity of patient care | | | | | |
| Advocated on behalf of a patient | | | | | |
| Demonstrated awareness of limitations | | | | | |
| Admitted errors/omissions | | | | | |
| Solicited feedback | | | | | |
| Accepted feedback | | | | | |
| Maintained appropriate boundaries | | | | | |
| Maintained composure in a difficult situation | | | | | |
| Maintained appropriate appearance | | | | | |
| Was on time | | | | | |
| Completed tasks in a reliable fashion | | | | | |
| Addressed own gaps in knowledge and skills | | | | | |
| Was available to colleagues | | | | | |
| Demonstrated respect for colleagues | | | | | |
| Avoided derogatory language | | | | | |
| Maintained patient confidentiality | | | | | |
| Used health resources appropriately | | | | | |

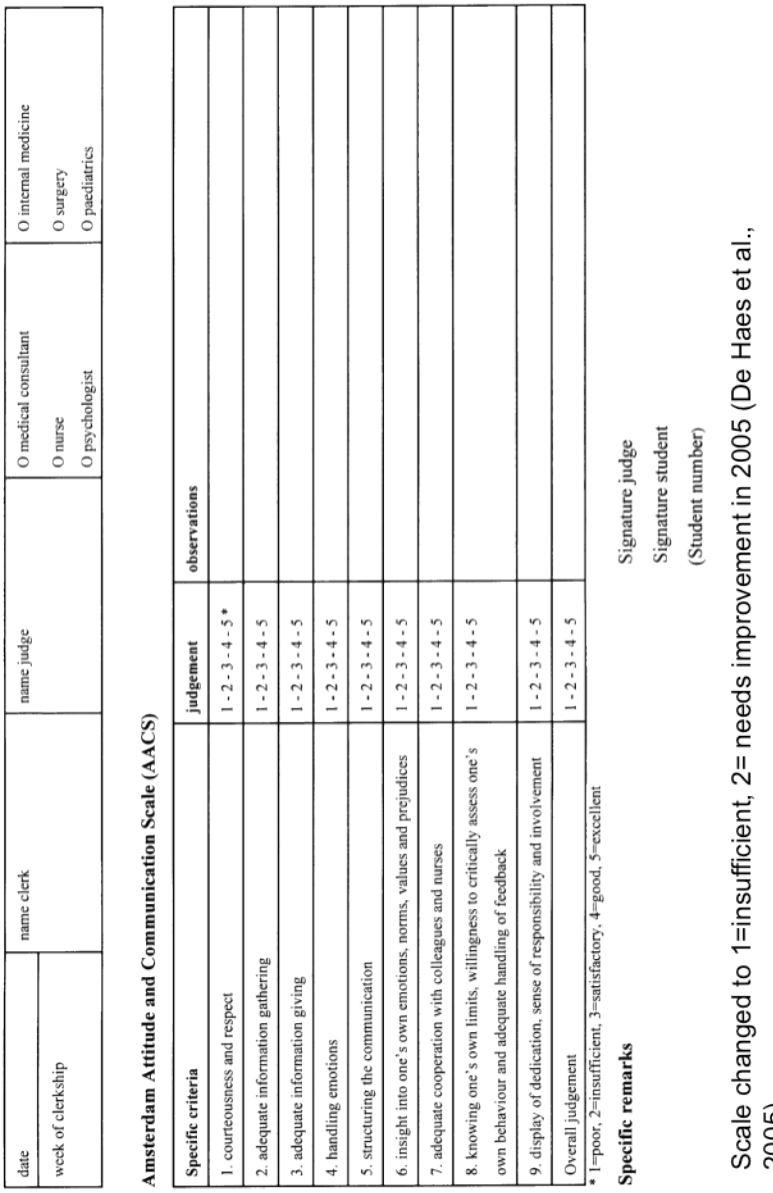
► Please rate this student's/resident's overall professional performance during THIS encounter: ⎕ UNacceptable ⎕ MET expectations
⎕ BELow expectations ⎕ EXCeeded expectations

► Did you observe a critical event? ⎕ no ⎕ yes (comment required)
Comments:_____
_____
_____
_____
_____

Evaluator's signature:_____
Student's/Resident's signature: _____
Date & Time:_____

***Figure 23 The P-MEX***

***(Cruess, 2012 reproduced with permission)***



| date | name clerk | name judge | O medical consultant | O internal medicine |
|---|---|---|---|---|
| week of clerkship | | | O nurse | O surgery |
| | | | O psychologist | O paediatrics |

**Amsterdam Attitude and Communication Scale (AACS)**

| Specific criteria | judgement | observations |
|---|---|---|
| 1. courteousness and respect | 1 - 2 - 3 - 4 - 5 * | |
| 2. adequate information gathering | 1 - 2 - 3 - 4 - 5 | |
| 3. adequate information giving | 1 - 2 - 3 - 4 - 5 | |
| 4. handling emotions | 1 - 2 - 3 - 4 - 5 | |
| 5. structuring the communication | 1 - 2 - 3 - 4 - 5 | |
| 6. insight into one's own emotions, norms, values and prejudices | 1 - 2 - 3 - 4 - 5 | |
| 7. adequate cooperation with colleagues and nurses | 1 - 2 - 3 - 4 - 5 | |
| 8. knowing one's own limits, willingness to critically assess one's own behaviour and adequate handling of feedback | 1 - 2 - 3 - 4 - 5 | |
| 9. display of dedication, sense of responsibility and involvement | 1 - 2 - 3 - 4 - 5 | |
| Overall judgement | 1 - 2 - 3 - 4 - 5 | |

* 1=poor, 2=insufficient, 3=satisfactory, 4=good, 5=excellent

**Specific remarks**

Signature judge

Signature student

(Student number)

Scale changed to 1=insufficient, 2= needs improvement in 2005 (De Haes et al., 2005)

***Figure 24 The Amsterdam Attitude and Communication Scale (reproduced from de Haes et al., 2001 with permission)***

Appendix C: P-MEX, Amsterdam Attitude and Communication Scale and SDOT

**CORD SDOT**
**Standardized Direct Observational Assessment Tool -- EM Outcomes Assessment**

This assessment tool, the SDOT, is designed to obtain objective data through observation of residents during actual ED patient encounters. Each item should be judged as either: "Needs Improvement (**NI**)," "Meets Expectations (**ME**)," "Above Expected (**AE**)," or "Not Assessed (**NA**)" for level of training.

| | | | |
|---|---|---|---|
| Resident's Name: | Evaluated by: | Date: | PGY: 1 2 3 4 |
| Time spent (minutes): | Patient complaint: | # of patients encounters observed: | |

| | NI | ME | AE | N/A | Category |
|---|---|---|---|---|---|
| DATA GATHERING | | | | | |
| 1. Respectful of patient's privacy and confidentiality. | | | | | PC, PR |
| 2. Appears professional, introduces self, and communicates efficiently and respectfully with patient, family and staff. | | | | | ICS, PR |
| 3. Uses language translation personnel when indicated. | | | | | ICS |
| 4. Efficiently gathers essential and accurate information from all available sources (i.e. patient, family, EMS, PMD, old records). | | | | | PC, SBP |
| 5. Performs complaint oriented physical exam and appropriate general exam for level of care. | | | | | PC |
| SYNTHESIS/ DDX | | | | | |
| 6. Can explain the pathologic basis for management. | | | | | MK |
| 7. Presents the case in a structured manner appropriate to the patients' condition/complexity. | | | | | MK, PC |
| 8. Discusses an appropriate differential diagnosis, treatment plan and disposition with the attending. | | | | | MK, PC |
| 9. Understands benefits, risks and indications for a therapy or procedure. | | | | | MK |
| MANAGEMENT | | | | | |
| 10. Appropriately sequences critical actions in patient care. | | | | | MK |
| 11. Competently performs a procedure, demonstrating knowledge of anatomy and observant of inherent risks. | | | | | MK, PC |
| 12. Communicates clearly, concisely, and professionally with colleagues and ancillary staff | | | | | ICS, PR |
| 13. Anticipates, negotiates, and effectively resolves conflicts that occur at the interface between patients, family, staff, and physicians. | | | | | ICS,SBP,PR |
| 14. Discusses and updates care plan with the patient or family. | | | | | PR, PC |
| 15. Clinical charting is timely, legible, and succinct, and reflects ED course and decision-making. | | | | | PC, PR |
| 16. Prioritizes patients appropriately by acuity and waiting time | | | | | SBP |
| 17. Plans patient work-up in the context of health care system limitations (staffing, consultants, testing availability) | | | | | SBP |
| 18. Plans work-up in view of patient's social constraints (i.e., ability to pay, family support, work issues, etc) | | | | | SBP |
| 19. Controls distractions and other priorities while maintaining focus on patient's care | | | | | SBP |
| 20. Makes informed diagnostic and treatment decisions using patient information and preferences, clinical judgment, and | | | | | PC |

| | NI | ME | AE | N/A | Category |
|---|---|---|---|---|---|
| scientific evidence | | | | | |
| 21. Reevaluates patient after therapeutic intervention and follows up on diagnostic tests. | | | | | PC |
| 22. Documents reassessment and response to therapeutic intervention. | | | | | PC |
| DISPOSITION | | | | | |
| 23. Uses resources such as social work and financial aid effectively | | | | | SBP |
| 24. Discharge plan discussed with patient in a compassionate, professional manner | | | | | PC, ICS, PR |
| 25. Carries out appropriate discharge/admission/transfer plan, including notification of accepting MD or PMD as indicated | | | | | PC, SBP |
| 26. Arranges patient follow-up with an understanding of outpatient resources and the patient's unique situation. | | | | | SBP |

## *GLOBAL ASSESSMENT OF CORE COMPETENCIES*

| **A. Patient Care** -that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health | | | | |
|---|---|---|---|---|
| **Needs Improvement** | | **Meets Expectations** | | **Above Expectation** |
| 1 | 2 | 3 | 4 | 5 |
| **Comments:** | | | | |

| **B. Medical Knowledge** - Residents are expected to formulate an appropriate differential diagnosis with special attention to life-threatening conditions, demonstrate the ability to utilize available medical resources effectively, and apply this knowledge to clinical decision making. | | | | |
|---|---|---|---|---|
| **Needs Improvement** | | **Meets Expectations** | | **Above Expectation** |
| 1 | 2 | 3 | 4 | 5 |
| **Comments:** | | | | |

| **D. Interpersonal and Communication Skills** -that result in effective information exchange and teaming with patients, their families, and other health professionals | | | | |
|---|---|---|---|---|
| **Needs Improvement** | | **Meets Expectations** | | **Above Expectation** |
| 1 | 2 | 3 | 4 | 5 |
| **Comments:** | | | | |

| **E. Professionalism** -as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population | | | | |
|---|---|---|---|---|
| **Needs Improvement** | | **Meets Expectations** | | **Above Expectation** |
| 1 | 2 | 3 | 4 | 5 |
| **Comments:** | | | | |

| **F. Systems-Based Practice** -as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value | | | | |
|---|---|---|---|---|
| **Needs Improvement** | | **Meets Expectations** | | **Above Expectation** |
| 1 | 2 | 3 | 4 | 5 |
| **Comments:** | | | | |

**Circle best description of overall clinical competence for this patient encounter**

**Needs Improvement** **Meets Expectations** **Above Expectations**

**Summary Comments (Faculty):**

**Resident Comments (Optional):**

***Figure 25 The SDOT (Standardized Direct Observation Tool)***
***(Council of Emergency Medical Residency Directors, 2005 with permission)***

# 13. Appendix D

Original interview questions and prompts

*Practice education facilitators [face to face]*

Demographics

How long have you been a PEF?

Semi-structured schedule:

Why do mentors contact you? What brings you into support them?

What is your role in supporting mentors and/or students?

Does this build on your own experiences as a mentor?

In your opinion, are mentors using the ISP in practice?

For what reasons?

What feedback are you getting around the ISP

How do you think the ISP is being used for students in practice?

Have you seen mentors use comments from 8 to 16? What do these types of comments indicate?

Are mentors aware of prior assessments?

Is the 'passport' being used after the first placement?

Is there anything else you would like to tell me?

*Education champions [face to face]*

In original design there were no Education Champions so PEF questions were adapted. Questions were asked around how the EC role was undertaken in their particular Trust or setting as this varied.

*Mentors [face to face or telephone]*

Demographic information: closed questions for quick info
How long have you been nursing? In the clinical area?
How long mentoring?
Any preparation? Courses?

Semi-structured schedule:

Is there a student in particular that you wanted to speak to me about?

How have you used the interpersonal skills profile? [will include ISP in information pack for mentors and suggest they have it so we are both looking at one for conversation]

Has it been useful?
What types of issues does it address?
If discuss which categories used – WHY and what did the category mean to this mentor?

What are the types of issues that flag up a struggling student?

What issues are there for you?

If you've got a student and you're not sure if they should pass or fail, what issues do you weigh up?

Who do you go to for support?

Is there anything else you would like to tell me?

**Once interviewing started and CMO were identified several prompts used for all interviews**

Questions on context:

EC: role of ec, perceived need? Mentorship preparation and ability

PEF: role of PEF, perceived need? Interaction with mentors, type of support (same as before, why get called in etc.)

Mentor: own setting, types of student etc.

All: older/younger students → maturity issues

where are students perceived to belong (college/clinical) and does that matter?

Eg. of behaviour/attitude/professionalism problems

Questions for mechanisms:

All: how was attitude and behaviour assessed?

does ISP support mentors in assessing students?

How? In what way?

What do you think of statements 6-14?

Does it matter that they are pass in first year and fail in 2nd and 3rd?

probe in interviews left about student self assessment: do they bring it in rough, transcribe if agree or change it if don't

Questions for outcome:

All: what do you think the impact of the ISP has been?

What is the impact of having items that fail in first year and not in 2nd and 3rd?

does this assessment help delineate a passing student from a failing student?

# 14. Appendix E

| Study Number | session 1 f → mod 1 0308 | session 1 s → mod 1 03/08 | module 2 f | module 2 s | module 3 f | module 3 s | module 4 f | module 4 s |
|---|---|---|---|---|---|---|---|---|
| **S030801** | 18,14,22, 26,27 | 21,23,28,18,19 | | | 24,27,28,30,32 | 24,27,28,30,32 | 19,22,23,27,30 | 17,19,23,27,28 |
| **S030802** | 25,28,29 31,34 | 24,29,22,23,18 | 18,23,27,15,19 | 14,19,23,26,21 | 26,31,35,38,39 | 37,32,33,28,38 | 19,23,25,27,29 | 19,23,25,27,29 |
| **S030803** | | | | | 26,27,28,29,33 | 22,23,30, 21,33 | | |
| **S030804** | 18,19,20,22,25 | 21,23,24,27,17 | 18,19,22,23,33 | 20,24,25,28,31 | 17,21,22,25,27 | 17,22,23,33,39 | 18,20,23,27,39 | 19,21,22,35,30 |
| **S030805** | 18,21,27,35,26 | 26,28,32,35,36 | | | 22,23,20,21,26 | 18,21,22,23,26 | 27,21,23,25,28 | 20,31,32,28,29 |
| **S090701** | | | | | | | | |
| **S090702** | 12,17,21,25,27 | 17,18,19,36,27 | | | 17,22,25,30,23 | 18,25,28,30,20 | 28,30,25,21,23 | 28,29,21,30,36 |
| **S090703** | 18,20,21,24,25 | 26,27,28,29,30 | | | 10,17,19,20,23 | | | 10,18,20,22,26 |
| **S090705** | 30,33,32,28,23 | 27,30,28,29,36 | | | 17,27,22,24,35 | 28,33,26,29,21 | 36,35,28,25,24 | 21,36,35,30,26 |
| **S090705** | 9,12,14,17,23 | 18,20,33,26,29 | | | 17,18,14,12,24 | 19,23,22,17,21 | 17,19,22,23,18 | 16,17,19,21,23 |
| **S090706** | | | | | 14,19,22,23,27 | 17,20,22,23,27 | 8,17,21,23,27 | 18,21,27,28,33 |
| **S030806** | 28,30,32,33,38 | 29,31,34,27,36 | 23,25,28,38,39 | 22,24,27,29,30 | 21,17,22,25,29 | 30,35,38,27,39 | 23,18,28,29,36 | 38,35,33,26,25 |
| **S030807** | 19,21,23,25,17 | 21,23,25,26,28 | 18,25,29,36,38 | 21,35,32,31,39 | 18,19,22,23,35 | 26,27,28,32,35 | 24,25,28,30,32 | 24,25,28,30,33 |
| **S030808** | 10,18,19,20,22 | 21,22,23,24,25 | | 18,25,22,23,27 | 22,28,25,30,24 | 26,27,28,36,38 | 17,20,23,25,22 | 18,22,28,30,24 |
| **S090707** | 39,38,37,36,35 | 39, 38,37,36,35 | | | 26,27,31,36, 38 | 20,28.30,34,35 | 34,35,36,38,39 | 34,35,36,38,39 |
| **S090708** | 22,24,25,23,27 | 25,28,36,33,29 | | | 27,20, 23,32,30 | 26,31,33,38,35 | 25,27,24,28,30 | 25,27,24,28,30 |
| **S090709** | 18,22,23,25,26 | 30,27,33,35,36 | | | 27,30,33,35,29 | 35,30,28,26,23 | 27,30,32,31,33 | 18,25,26,32,24 |
| **S090710** | 17,18,19,20,22 | 23,24,25,27,28. | | | 18,27,28,35,38 | 18,21,29,30,34 | 22,23,27,30,36 | 18,22,27,28,30 |
| **S090711** | 9,14,17,19,20 | 18,19,20,21,22 | | | 9,17,27,29,35 | 18,19,20,26,31 | 18,17,27,28,20 | 19,29,27,18,24 |
| **S090712** | 23,24,28,22,27 | 29,30,32,36,35) | | | 17,19,23,25,27 | 33,35,38,21,20 | 8,9,21,22,35 | 18,19,20,26,29 |

| Study Number | module 5 f →3 for adult field | module 5 s → 3 for adult field | module 6 f | module 6 s | module 7 f | module 7 s | module 8 f | module 8 s |
|---|---|---|---|---|---|---|---|---|
| **S030801** | 22,26,27,33,25 | 28,33,27,26,22 | | | 10,11,16,17,4 | 10,11,16,15,4 | 9,10,12,14,16 | 4,17,18,8,19 |
| **S030802** | 26,23,35,32,30 | 28,32,25,24,34 | | | 17,21,26,32,35 | 3,29,35,36,37 | 19,20,24,27,35 | 21,23,24,31,35 |
| **S030803** | 23,24,25,30,26 | 37, 22, 25,24,26 | | | 21,24,26,27,19 | 28,29,30,32,34 | 23,25,26,30,35 | 20,21,24,28,33 |
| **S030804** | 20,22,23,19,18 | 24,26,27,30,35 | | | 22,23,24,25,27 | 34,35,36,38,39 | 30,25,32,24,28 | 34,35,36,38,39 |
| **S030805** | 19,24,27,25,20 | 24,26,31,33,27 | | | 18,25,352628 | 20,21,23,31,38 | 18,21,22,25,27 | 25,29,32,34,36 |
| **S090701** | | | | | | | 17,18,21,33,28 | 34,32,30,29,35 |
| **S090702** | 8,13,16,15,18 | 28,30,33,36,25 | | | 27,29,35,34,21 | | 26,27,29,31,33 | 26,36,29,34,31 |
| **S090703** | 19,25,26,22,30 | 30,26,32,33,35 | | | 19,21,23,24,30 | 19,22,23,28,30 | 17,19,21,22,23 | 25,15,22,30,29 |
| **S090705** | 19,17,22,24,27 | 25,26,27,30,35 | | | 21,22,26,27,32 | 23,24,25,28,30 | 30,33,35,36,38 | 30,32,33,36,38 |
| **S090705** | 18,23,22,19,26 | 20,22,26,27,33 | | | 22,24,27,30,35 | 36,34,33,30,27 | 34,26,38,30,35 | 24,27,30,32,35 |
| **S090706** | 25,27,30,32,33 | 26,17,29,30,39. | | | 22,23,24,25,27 | 28,29,30,26,36 | 22,30,23,20,25 | 21,30,24,22,23 |
| **S030806** | 25,39,28,38,29 | 39,38,36,35,30 | | | 30,33,35,36,38 | 32,35,36,38,39 | 23,25,30,38,29 | 33,35,36,38,39 |
| **S030807** | 20,24,26,27,32 | 29,31,21,25,36 | | | 25,28,33,36,23 | 36,38,32,23,22 | 18,31,24,38,27 | 18,22,24,28,38 |
| **S030808** | 30,31,27,32,39 | 21,22,23,24,25 | | | 23,25,27,28,30 | 24,29,30,33,36 | | |
| **S090707** | 21,22,23,30,37 | 21,22,24,25,30 | 34,35,37,38,39 | 36,30,31,38,39 | 30,33,34,35,37 | 35,36,37,38,39 | 27,30,31,35,33 | 28,30,32,23,39 |
| **S090708** | 18,24,27,29,36 | 33,29,36,38,34 | 27,28,29,33,36 | 27,35,33,32,26 | 18,23,27,28,25 | 38,34,36,32,39 | | |
| **S090709** | 17,19,21,23,25 | 17,21,23,26,27 | 30,31,35,36,32 | 34,35,36,37,38 | 31,25,32,18,35 | 38,36,34,21,30 | 36,35,31,32,33 | 39,38,37,36,34 |
| **S090710** | 17,19,20,21,23 | 14, 19,25,26,28 | | | 22,23,24,25,28 | 17,18,24,25,27 | 18,20,22,24,27 | 25,26,28,30,36 |
| **S090711** | 17,20,22,24,26 | 26,29,27,28,35 | | | 31,33,34,35,38 | 30,32,35,36,38 | 14,31,19,24,33 | 26,28,31,20,36 |
| **S090712** | 21,25,26,27,28 | 22,23,26,27,28 | | | 19,25,27,28,30 | 20,26,32,33,36 | 21,22,24,25,27 | 27,30,31,35,36 |

***Figure 26 ISP numbers selected in documentary analysis***

# 15. Appendix F

### Codes and definitions of codes

Miscellaneous codes

- AHP [Allied Health Professionals]
    - things about AHPs
- interrupt/intermit
    - mostly raised by ECs as a strategy when students are failing
    - also that when students fail they bring another book with them...
        - context Education Champions <is associated with>
        - context uni changes <is associated with>
- prompt
    - comments that reminds them to assess/guides interpersonal skills
- tool: comments or use
    - the ISP tool, about comments or how it is used, overall feeling about impact of it, including not using it"
        - <is cause of> mech: explicit
        - <is associated with> mech: formative assessment
        - context mentor variation <is cause of>
        - mech: borderline comments <is part of>

Context codes

- context age
    - comments about age/maturity of student as a context not assessment issue
    - may overlap with mechanism, may be other factors around foreign students etc. too, attitude and insight, where student belongs
- context CLE [Clinical Learning Environment]
    - not just generic busy-ness but difference amongst particular settings, variation, eg. community, children, MH etc.… specialised areas"
        - <impacts on> context mentor variation
- context cluster skills
    - explicit reference to cluster skills and signing off on skills
    - this may overlap with document simplicity
- context doc
    - perception of document as a whole
    - context in which it's being used eg students having read the learning outcomes before coming to placement
    - use of learning contracts
    - other doc from other uni [second HEI has placements in some of the same places as study HEI]
        - <impacts on> context mentor variation
        - context uni changes <is associated with>
- context Education Champions
    - Education champions ‡ audit clinical areas, CLE, mentorship and student support
    - Role when the personal tutor can't see they are too involved

        - <impacts on> context mentor variation
        - <is associated with> interrupt/intermit
        - context uni changes <is cause of>
- context mentor prep
    - updates, supporting with docs, provide workbooks etc.
    - includes preparation for ISP"
        - <impacts on> context mentor variation
        - <is part of> context slaip [Standards for Learning and Assessment in Practice]
        - context PEF variation <is associated with>
- context mentor variation
    - not mentor prep but differences between mentors in assessing
    - norm/criteria referencing etc.
    - what mentors feel comfortable doing
    - if mentors could know about previous achievement, passport
    - mentoring differences in branches like MH vs. child etc.
        - <is cause of> tool: comments or use
        - context CLE <impacts on>
        - context doc <impacts on>
        - context Education Champions <impacts on>
        - context mentor prep <impacts on>
        - context organisation of placements <impacts on>
        - context PEF variation <impacts on>
        - context pressure <impacts on>
        - context situation prior <impacts on>
        - context slaip <impacts on>
- context organisation of placements
    - session 3 and 5 particularly, how organised, students in/out of placement etc.
    - part time programme (one setting)
        - <impacts on> context mentor variation
        - context uni changes <is associated with>
- context PEF variation
    - how PEFs support mentors/students
    - who they are
    - constraints to role as well
        - <is associated with> context mentor prep
        - <impacts on> context mentor variation
- context pressure
    - generic issues on numbers and hospital as a whole
    - time frame of the relationship (student/mentor)
    - ward busy-ness
        - <impacts on> context mentor variation
- context situation prior
    - situation before ISP and other changes
    - including students no longer part of the workforce, expectations of behaviour
        - <impacts on> context mentor variation
        - <is cause of> context uni changes
- context slaip [Standards for Learning and Assessment in Practice]
    - factors around slaip and NMC awareness (incld references to Duffy)

    - gatekeeping role
    - <impacts on> context mentor variation
    - context mentor prep <is part of>
- context uni changes
    - things the HEI has changed, may overlap with comments about EC also just comments about HEI
    - comments about assessment practices vary amongst respondents, e.g. PEF01 says more strict, EC4 says more lax
    - difficulty in failing off a course
        - <is associated with> context doc
        - <is cause of> context Education Champions
        - <is associated with> context organisation of placements
        - <is associated with> interrupt/intermit
        - context situation prior <is cause of>
- context: student
    - other things students are doing
    - sickness, disability, personal issues
    - previous healthcare experience of not
    - students no longer part of the workforce
        - <impacts on> mech: formative assessment
- context: ward
    - the wards ability to support or not, do paper work etc.

<u>Mechanism codes</u>

- mech: borderline comments
    - comments that are explicitly borderline and labelled as such
    - comments 8-16 incld if I ask about them ask about p/f aspect
        - <is part of> tool: comments or use
- mech: confidence
    - confidence to comment on interpersonal aspects, confidence to fail
    - lack of confidence
    - lack of confidence to write learning contracts
        - <is part of> out: confidence
        - mech: emotional <is part of>
- mech: distance
    - the HEI's document
    - just write a number, don't need to come up with comments, select
    - ownership of assessment
        - <impacts on> mech: subjectivity
        - mech: emotional <is associated with>
- mech: earlier failing
    - don't get to management placement to become problematic
    - incld discussion on management first time started getting assessed on those skills
    - or earlier identification of problems
    - or opposite, delayed identification"
        - mech: formative assessment <is cause of>
- mech: emotional
    - emotional side of failing students
    - ?opposite of distance

    - role conflict/tension for mentors: assessment of patients as nurses and assessment of students as mentor, more time could improve performance, reluctant to comment
    - incld AHPs where assessment is part of University
    - mentors assess themselves and their own judgement
        - <is part of> mech: confidence
        - <is associated with> mech: distance
- mech: explicit
    - permission to fail or comment, normalisation of assessing these
    - student awareness also
    - guide
    - less need for pef support (see also outcome confidence)
    - how to do it
    - connectedness of clinical skills and interpersonal skills
    - raise profile of ISP
    - student can challenge
        - <is cause of> mech: confidence
        - <is part of> mech: identify what are att/beh
        - <is cause of> mech: place to document
        - <contradicts> mech: subjectivity
        - mech: distance <is property of>
        - mech: quicker <is property of>
        - tool: comments or use <is cause of>
- mech: facilitates
    - item recoded from tools comment or use that fits into the mechanism facilitates
- mech: formative assessment
    - early warning, allows for development
    - reference to midpoint assessment
    - what happens after feedback given?
    - formative for placement or course?
    - hypothetical formative, tell the student this is where you would be if I assessed you now...
        - <is cause of> mech: earlier failing
        - <is cause of> out: earlier fail
        - <is cause of> out: earlier improve
        - context: student <impacts on>
        - tool: comments or use <is associated with>
- mech: identify what are att/beh [attitudes and behaviours]
    - examples of attitude, behavioural and professionalism problems
    - including when wrongly identified
    - are they teachable?
        - <impacts on> mech: subjectivity
- mech: less daunting
    - use of mechanisms, less daunting
    - incld quotes that show some complication where not easier
        - <is property of> mech: explicit
- mech: other failing issues
    - things not related to ISP issues that might fail or risk failure or failing items on ISP
- mech: place to document

    - actual place to write concerns down
    - evidence to support failing or nearly failing
    - incld lack of evidence
    - structure of ISP tool
- mech: quicker
    - it's quicker so actually do it instead of lengthy work,
    - ?possible fall out issues
- mech: socialization
    - as looking through see which in tools actually fit different mechanisms better
        - <impacts on> out: consequences
- mech: subjectivity
    - subjectivity of assessment either denied or example given
    - also difference between perception and intended behaviour on students' part
    - number of people assessing/timeframe
        - mech: explicit <contradicts>
        - mech: distance <impacts on>
        - mech: identify what are att/beh <impacts on>

<u>Outcome codes</u>

- out: confidence
    - mentors actually are more confident
    - evidence of competence to not need the PEF's support, outcome then maybe increased independence in assessment
        - mech: confidence <is part of>
- out: consequences
    - consequences of ISP...impact on student, eg realise can fail
    - impact of being assessed on ISP to student
        - mech: socialisation <impacts on>
- out: define pass/fail
    - does the tool allow to delineate/define a passing or failing student?
        - <is associated with> out: earlier fail
        - <is associated with> out: earlier improve
- out: earlier fail
    - leaving the programme earlier so not getting to final year to be failed
    - also the opposite
        - mech: formative assessment <is cause of>
        - out: define pass/fail <is associated with>
        - out: earlier improve <is associated with>
- out: earlier improve
    - earlier comments give time to change/address issues
        - <is associated with> out: earlier fail
        - mech: formative assessment <is cause of>
        - out: define pass/fail <is associated with>
- out: interpersonal skills assessed
    - comments around interpersonal skills actually getting assessed...could be some overlap with situation prior

# 16. Appendix G

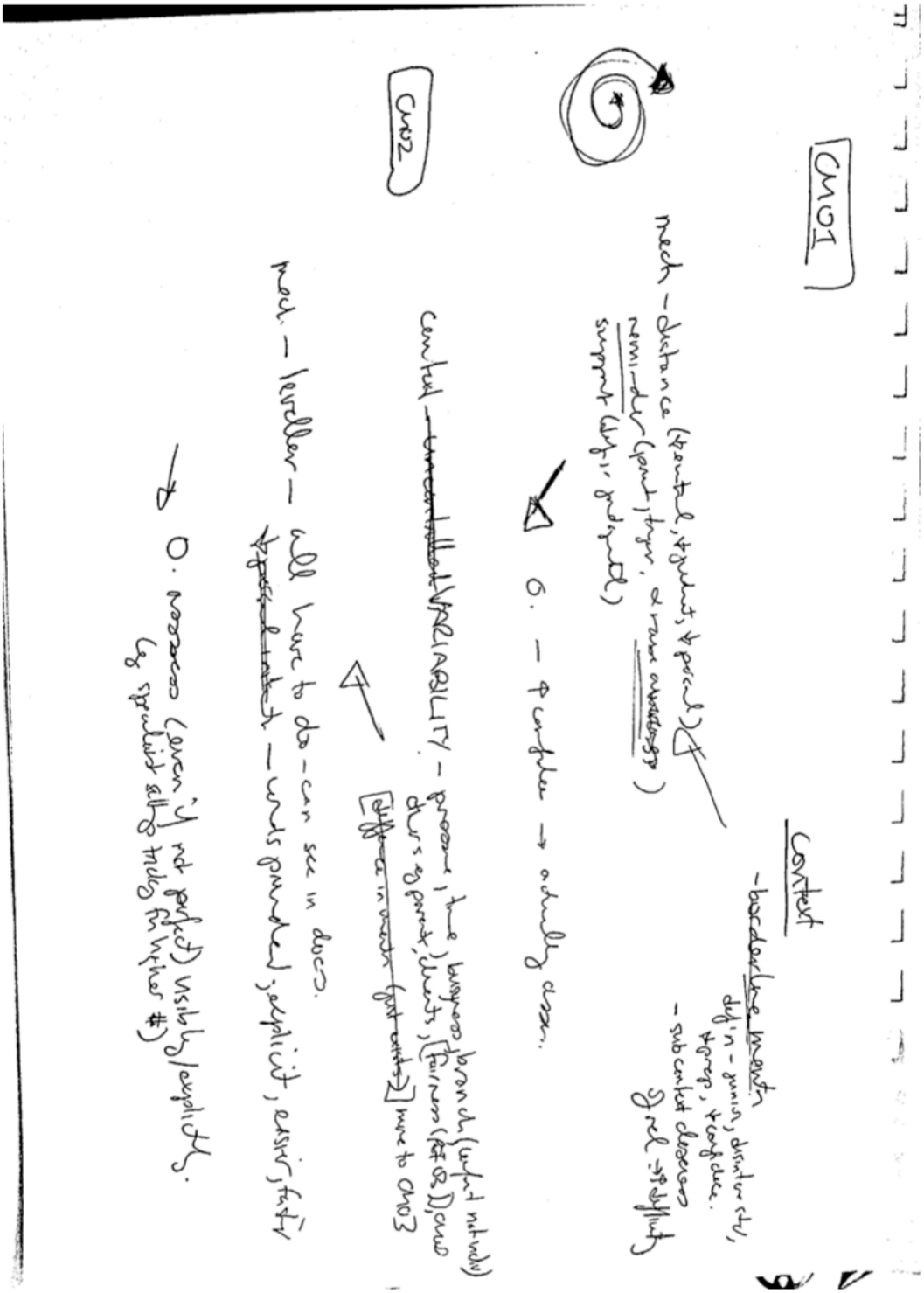



***Figure 27 Example of early development of CMO1***

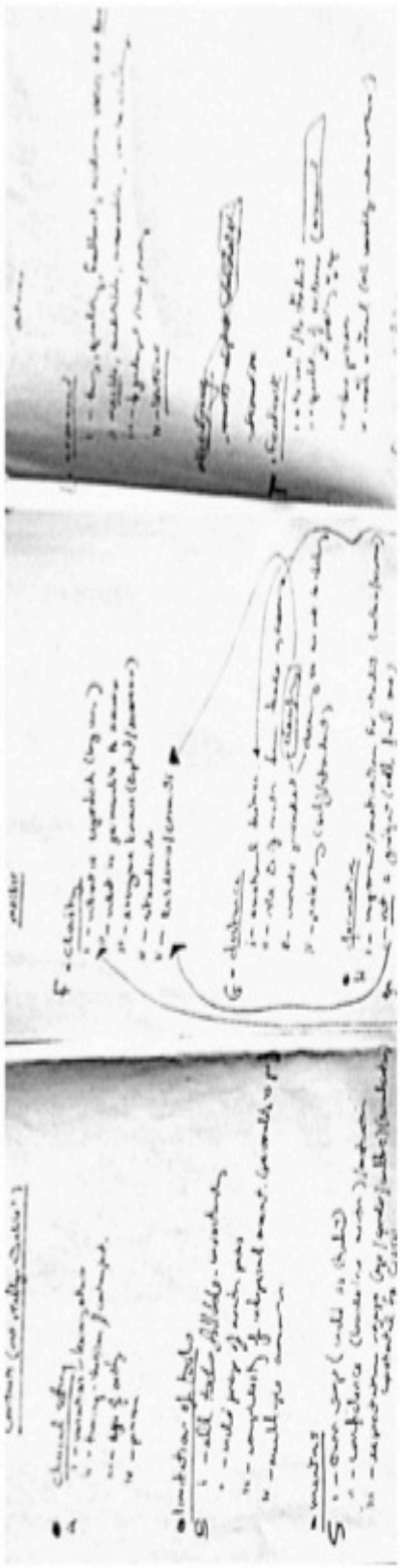


***Figure 28 Example of early development of CMOs***

# 17. Appendix H

***Figure 29 Coventry University (2012) Interpersonal Profile***

**YEAR ONE INTERPERSONAL PROFILE**

Please complete by circling 'pass' or 'fail' against each of the minimum standards under the relevant column ie midway or final. In addition for students who are working consistently above the minimum standards in aspects of their work please indicate by circling a 'D' under the appropriate 'statement of distinction'.

| **Section A – PROFESSIONALISM – Minimum Standards** | **Midway** | | **Final Week** | |
|---|---|---|---|---|
| Meets the professional expectations for a first year student nurse | Pass | Fail | Pass | Fail |
| Reliable and punctual, good time management | Pass | Fail | Pass | Fail |
| Consistent in meeting professional codes of conduct | Pass | Fail | Pass | Fail |
| Takes responsibility appropriate for a first year student nurse | Pass | Fail | Pass | Fail |
| Demonstrates appropriate social, cultural, religious and ethical sensitivity | Pass | Fail | Pass | Fail |
| **OUTCOME** | **PASS** | **FAIL** | **PASS** | **FAIL** |
| **STATEMENT OF DISTINCTION** | | | | |
| Shows a good understanding of the concept of professional nursing | **D** | | **D** | |
| Consistently works at a higher level than expected | **D** | | **D** | |
| **Section B – PERSONAL QUALITIES AND APROACH TO LEARNING – Minimum Standards** | | | | |
| Displays a positive attitude | Pass | Fail | Pass | Fail |
| Shows an awareness of own learning needs | Pass | Fail | Pass | Fail |
| Reacts positively to constructive criticism | Pass | Fail | Pass | Fail |
| Shows self awareness and understanding of the effect of their behaviour on others | Pass | Fail | Pass | Fail |
| Makes use of learning opportunities | Pass | Fail | Pass | Fail |
| Assimilates new information appropriately | Pass | Fail | Pass | Fail |
| Well motivated and adaptable | Pass | Fail | Pass | Fail |
| **OVERALL OUTCOME** | **PASS** | **FAIL** | **PASS** | **FAIL** |
| **STATEMENTS OF DISTINCTION** | | | | |
| Offers informed and considered opinions | **D** | | **D** | |
| Innovative, develops fresh ideas | **D** | | **D** | |
| Identifies and acts upon own learning needs | **D** | | **D** | |
| Analytical in approach, drawing from a wide range of sources | **D** | | **D** | |
| **Section C – PRACTICAL PERFORMANCE – Minimum Standards** | | | | |
| Has made progress in practice | Pass | Fail | Pass | Fail |
| Shows a degree of confidence which enhances performance | Pass | Fail | Pass | Fail |
| Capable of informed decision making appropriate for a first year student nurse | Pass | Fail | Pass | Fail |
| Accepts appropriate responsibility | Pass | Fail | Pass | Fail |
| **OVERALL OUTCOME** | **PASS** | **FAIL** | **PASS** | **FAIL** |
| **STATEMENTS OF DISTINCTION** | | | | |
| Acts on initiative appropriate to a first year student nurse | **D** | | **D** | |
| Consistently works to a higher level than expected | **D** | | **D** | |
| Realistically evaluates own performance | **D** | | **D** | |
| **Section D – TEAM WORKING – Minimum Standards** | | | | |
| Has made a useful contribution to the work of the team | Pass | Fail | Pass | Fail |
| Shows an understanding of the need for team working | Pass | Fail | Pass | Fail |
| Communicates effectively with members of the team appropriate for a first year student nurse | Pass | Fail | Pass | Fail |
| **OVERALL OUTCOME** | **PASS** | **FAIL** | **PASS** | **FAIL** |
| **STATEMENTS OF DISTINCTION** | | | | |
| Can initiate appropriate information with members of the team | **D** | | **D** | |
| A valued team member who has gained respect | **D** | | **D** | |
| **TOTAL NUMBER OF DISTINCTIONS** | | | | |
| **Signature of Mentor** | | | | |

| OUTCOME Minimum Standards | PASS | FAIL | Signature of Mentor |
|---|---|---|---|

| Signature of Student: | Signature of Personal Tutor: |
|---|---|

**NB**: ANY FAIL IN THE FINAL WEEK COLUMN WILL REQUIRE THE STUDENT TO HAVE A SECOND ATTEMPT AT THIS MODULE. FAIL AT SECOND ATTEMPT WILL RESULT IN THE STUDENT FAILING STANDARD FOR THE COURSE

NOT FOR USE

**INTERPERSONAL SKILLS PROFILE**
**Mid-point (Progress to date)**

| Name of Student: | Cohort: |
|---|---|

| Please select FIVE comments from the list, which most nearly describe the performance of the student. | |
|---|---|
| 1. Unsafe to practice | 20. Assimilates new information |
| 2. Behaves in an unprofessional manner | 21. Accepts appropriate responsibility |
| 3. Displays a negative attitude | 22. Fits well into the team |
| 4. Blames circumstances for difficulties encountered | 23. Has a pleasant and approachable manner |
| 5. Appears to lack motivation | 24. Displays a mature attitude |
| 6. Does not define learning needs | 25. Well motivated and adaptable |
| 7. Lacks self-awareness an the effect of behaviour on others | 26. Is able to reflect on outcomes |
| 8. Needs to take responsibility appropriate for this level | 27. Identifies own learning needs |
| 9. Lack of confidence inhibits effective performance | 28. Has made a useful contribution to the work of the team |
| 10. Needs more experience at this level | 29. Shows a good understanding of the concepts of paramedic care |
| 11. Reacts adversely to constructive criticism | 30. Displays confidence |
| 12. Slow to settle | 31. Analytical in approach, drawing from a wide range of sources |
| 13. Lacks maturity | 32. Offers informed and considered opinions |
| 14. Needs to be more assertive | 33. Realistically evaluates performance |
| 15. Could have made more use of available resources | 34. Capable of informed decision-making |
| 16. Has not achieved full potential | 35. Shows a mature understanding |
| 17. Willing to try | 36. Valued team member who has gained respect |
| 18. Has developed in confidence | 37. Innovative, develops fresh ideas |
| 19. Skills will develop with practice | 38. Consistently works at a higher level than expected |
| | 39. An excellent performer in all areas |

**WRITE THE NUMBERS OF THE COMMENTS WHICH YOU HAVE SELECTED IN BOXES BELOW**

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|---|---|---|---|---|
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|---|---|
| Signature of PPEd: | Date: |
| Signature of Student: | Date: |

***Figure 30 University of Western England (2012) Interpersonal Skills Profile***